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ABSTRACT

This guide is designed primarily for use by personnel involved in North Dakota public school programs for preschool-age handicapped children (ages 3-5). It is also intended to provide parents and personnel in health, human services, and other child service agencies with an understanding of the scope and purpose of educational services for young handicapped children and their families. It begins with a review of the underlying philosophy and history of such services in North Dakota and provides a reprint of the state's regulations governing eligibility, placement, teacher qualifications, and facilities. A section on program planning discusses goals and objectives, the range of available service delivery options, services to families and family involvement, staffing, and administration. Identification and programming is covered in another section that describes the Child Find system, the assessment process, and individualized education plans. Appendices provide: (1) descriptions of theoretical models in curricula and assessment; (2) classroom organization guidelines; (3) lists of educational materials and toys for handicapped preschoolers with names and addresses of manufacturers/suppliers; (4) descriptions of basic assessment tools and screening instruments; (5) lists of self-help groups and voluntary organizations in medical genetics and maternal and child health; and (6) a pamphlet on transition to school-age programs. (VW)

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SPECIAL EDUCATION IN NORTH DAKOTA

GUIDE VII
EARLY CHILDHOOD EDUCATION FOR HANDICAPPED CHILDREN
(Ages 3 through 5)

GUIDELINES

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THE STATE OF NORTH DAKOTA
Department of Public Instruction
Dr. Wayne G. Sanstead, Superintendent
BISMARCK, NORTH DAKOTA 58505

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Guide VII

Early Childhood Education for Handicapped Children (Ages 3 through 5)

March, 1985

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THE STATE OF NORTH DAKOTA
Department of Public Instruction
Dr. Wayne G. Sanstead, Superintendent (701) 224-2260

FOREWORD

The Department of Public Instruction presents Guide VII, Early Childhood Education for Handicapped Children, to special education and regular education personnel in North Dakota schools, to parents, and to agency personnel serving young handicapped children and their families. It is hoped that Guide VII will serve as a resource to individuals and groups as the task of establishing comprehensive services for young handicapped children is accomplished.

Early childhood services for handicapped children have been a stated need in North Dakota's Education of the Handicapped Act (P.L. 91-230) Plan since 1973. The earliest goal statement regarding early childhood services for handicapped children appears in the July 1, 1976, FY 1976, Part B, Education of the Handicapped Act as amended by P.L. 93-380 State Plan. The goal as stated indicated full services for 3-5 year olds by 1980. The date for the goal was later modified in the FY 1978, P.L. 94-142 State Plan to 1985. We are very proud that the 1985 goal will be achieved with the assistance of a mandate passed by the 1983 Legislative Assembly.

Another enabling force for the achievement of the full services goal for 3-5 year old handicapped children should be mentioned. In the spring of 1983 the Department of Public Instruction wrote a State Implementation Grant which was funded September 1, 1983 and enabled the department to put together the North Dakota Early Childhood State Plan for a Comprehensive Delivery System of Special Education and Related Services.

The tremendous growth in early childhood services for handicapped children over the past 10 to 15 years in North Dakota and across the nation is the result of increased public awareness of the benefits of services to young handicapped children and their families. Children are better able to benefit from educational experiences in the schools when important foundations to learning have been laid in preschool programs.

Gary Gronberg, Ed.D.
Director of Special Education
Department of Public Instruction
March 25, 1985

AN INTRODUCTION

The purpose of Guide VII, Early Childhood Education for Handicapped Children in North Dakota, is to provide direction for program growth and development in the state. This is a timely objective since fairly significant growth in services to preschool-age handicapped children is expected with the July, 1985 mandate. This focus on early childhood education for handicapped children also provides impetus for growth and development in existing programs as they determine whether full and comprehensive services are available to young handicapped children in their respective special education units.

Historically, North Dakota has recognized the importance of providing services to young handicapped children as indicated by the number of programs that have been established since special education services were mandated in the state in 1973. Though early childhood education for handicapped children has been a permissive service during the time period since 1973, the majority of special education units have provided programming to all or some of the handicapped 3 through 5 year old children in their local areas. In 1977, the North Dakota legislature added foundation aide support for early childhood programs for handicapped children. More recently, North Dakota's commitment is evidenced by the inclusion of early childhood education for handicapped children in those handicapping areas covered by state statute (effective July, 1985).

Guide VII has been prepared for use by personnel involved in services to preschool-age handicapped children. The principal audience for the guide will be professionals in public school programs for young handicapped children (ages 3 through 5) and supervisory personnel. It is also hoped that the guide will provide parents and personnel in health, human services and other child service agencies with an understanding of the scope and purpose of educational services for young handicapped children and their families.

Guide VII is intended to outline a process for planning, review and evaluation of programs for young handicapped children. An attempt has been made throughout the guide to be sensitive to variances across the state that affect this process. These variances include differences between rural vs. urban areas, new and developing programs vs. established programs in the process of refining procedures and/or expanding services, large special education units with many services vs. smaller units with more limited services and resources.

The guide is not intended to set all special education units on a course of providing identical programs. It is rather to offer suggestions and alternatives from which personnel may choose as they develop the program that best fits the needs of the individual children served and the local area.

Brenda K. Oas

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Several professionals from around the state have given their time and talents to development of Guide VII, Early Childhood Education for Handicapped Children in North Dakota. Of particular note are the contributions of four teachers of young handicapped children who assisted in much of the planning and early research and writing of the guide. Their knowledge of their own programs and the children they serve provided the practical emphasis of the guide. They are:

Vicki Boehnke (Peace Garden Special Education Unit)

Marcia Gums (Buffalo Valley Special Education Unit)

Sharon Hanson (Dickinson Special Education Unit)

Nancy Heimark (Grand Forks Special Education Unit)

Appreciation is extended to special education directors, early childhood special education program coordinators, teachers of preschool handicapped children and infant development program personnel who participated in on-site interviews and responded to extensive surveys regarding program needs during the 1983-84 school year. This information along with other data collected by the Department of Public Instruction over the years substantiated the issues to be addressed by the guide. These additional data sources included the following: monitoring, self study, and end-of-year reports required by the Department; program applications; technical assistance requests; and discussions with school administrators, special education directors, teachers and other school personnel, parents, other agency personnel, and representatives of organizations such as the Association for Retarded Citizens (ARC), the North Dakota Association for the Education of Young Children (NDAEYC), the North Dakota Association for Persons with Severe Handicaps (NDASH), and other advocates.

A special note of thanks goes to individuals who assisted in the review of Guide VII at various stages of development: Sallie Daner (Director, South Valley Special Education Unit), Dr. David Sapp (Director, Griggs/Steele/Traill Special Education Unit), Tom Cummings (Director, Pembina County Special Education Unit), Carole Peterson (Grand Forks Special Education Unit), Dr. Michael Conn-Powers (University of North Dakota), Dr. Ann Bisno (University of California at Northridge), members of the Parent Advisory Committee, and Department of Public Instruction staff members. The input provided in these reviews was extremely helpful and much appreciated.

These acknowledgements would not be complete without recognizing the efforts of Dee Hanson, who spent countless hours typing the many revisions of this guide, and Department of Public Instruction support services personnel who assisted with the format, diagrams and appendices.

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Early Childhood Education for Handicapped Children

A Philosophy

Providing special care for young handicapped children has long been recognized as sound planning. Early stimulation, preventive physical treatment, general medical and health care have been recommended at as early an age as possible by public and private agencies. Little has been done, however, to clearly define the role of education for the very young handicapped child.

Special Education programs today affirm a commitment to offer educational services at whatever age is necessary in order for handicapped children to benefit as much as possible from lifelong educational opportunities. The philosophy that undergirds this commitment sets the tone for the type and extent of educational options.

A Child-Family Centered Service

The needs experienced by the family in the normal process of child care remain a central factor as the educational needs of these very young handicapped children are considered. An underlying philosophy in early childhood education for the handicapped, therefore, is a focus on the needs of the child and family as each interacts and responds to the uniqueness of the other. All aspects of educational planning -- assessing and facilitating development, preparation and follow-up of appropriate activities -- must include considerations of the critical elements of the child-family situation. Planning and supervising such tasks call as much for skills in understanding and responding to adult needs as they do child care skills. This becomes a critical factor in selecting program personnel.

Comprehensive services to meet the child's total needs, with a safeguard against unnecessary fragmentation of separate services.

No single discipline includes the full body of knowledge necessary to tune in to all aspects of the handicapped child's needs and circumstances. To achieve the desired range of child-family services, an interagency and interdisciplinary

sharing of skills and responsibilities has come to be accepted as the only reliable plan. However, the more that each professional group seeks to provide the best its profession has to offer, the more they must be alert for possible coordination pitfalls. A combination of many professional persons, agencies, and programs, if allowed to do so, can become a number of fragmented service providers, preoccupied with the mechanics of communication and coordination.

Instead of engaging all professional groups who have "something" to offer young handicapped children in an attempt to build a full service team, personnel in early childhood programs must seek and wisely use specialized input that best matches the unique child-family need at a given time. Comprehensive special education services for the very young handicapped child, therefore, are dependent on careful observations of the ever changing profile of child-family functioning.

Special Education Services are provided to enable young handicapped children to benefit from a formal education when they reach school age.

Historically, schools have assumed responsibility for the education of children at an entering age of 5 or 6. Extending the school's responsibility downward to a nursery, toddler and even infant age, therefore, requires an explanation.

A justification for early childhood education programs for handicapped children emerges from the right and privilege of all children to benefit from opportunities provided during school years. For the handicapped child to benefit may mean:

Direct instruction for skills other children typically attain without instruction.

Using specially designed equipment or exercise routines to build physical strength for daily living tasks.

Administering medication or other health-related services to modify handicaps that may prevent school attendance.

These become part of the child's educational activities or a related service. For most handicapped children, age 5 or 6 is far too late to initiate such activities.

To teach the preschool age child requires a strong infant and child development basis.

It is not enough for program personnel to have a good grasp of the academic skills the young child is expected to develop. Teachers and other personnel must begin with a strong understanding of infant and child development upon which the child's new learning can be structured, rather than attempting to modify academic skills downward to infant and toddler levels. Competence in infant and child development, therefore, is a critical component for personnel in these programs.

State Commitment

Special education programs in North Dakota take their place along with programs in other states in providing educational and support services to young handicapped children. The Special Education Division of the State Department of Public Instruction will assist in the planning and development of these services. Partial reimbursement from state special education funds is provided for all approved programs.

History of Early Childhood Education for Handicapped Children

On a national basis, the history of services to handicapped children goes back to the early 1800's with the establishment of the first schools for the deaf and the blind. By comparison, services specifically for young handicapped children have had a much shorter history.

Many of the changes in programs for school-age handicapped children were brought about through litigation based on societal inequities such as handicapped children being excluded from schools or denied appropriate services (Mandell and Fiscus, 1980). For preschool children, there is no comparable free public education program for nonhandicapped children so, without the basis of societal inequity, provision of services to handicapped preschool children has been brought about more slowly.

The increase in programs for young handicapped children over the past twenty years has been supported by the impetus of P.L. 94-142 (1975) which includes the age range three through five in its mandate for free appropriate public education for handicapped children, though state statute is given precedence when age limitations differ from the P.L. 94-142 regulations (34 CFR 300.300). As of 1984, twenty-eight states mandate services to some or all of the young handicapped children under age 5. Ten of these states mandate services from birth.

Another avenue of support for early childhood programs for handicapped children has been federal grant funding for development and dissemination of "model" programs. The grant programs are part of the Handicapped Children's Early Education Assistance Act (P.L. 90-538) passed by Congress in 1968. States, universities, medical facilities, and local programs continue to apply for and receive grant funding through this program.

Early childhood programs for handicapped children have also been supported by increased public awareness about early childhood development, research studies with young handicapped or disadvantaged children, social advocacy, medical breakthroughs, and other factors that serve to change public knowledge and attitudes.

North Dakota Programs

Prior to 1970, some private and state operated programs provided services to preschool age handicapped children in North Dakota. Most of them placed a major

focus on parent education and on early planning, rather than implementing ongoing, full-year educational programs.

As early as the 1950's the Anne Carlsen School in Jamestown enrolled physically handicapped children of preschool age during the summer months. Children were in residence for a four-week period; parents participated approximately half of that period. The primary focus was on evaluation and parent training. Also of significance in early parent training were the Crippled Children's Clinics conducted regionally by the Easter Seal Society of North Dakota. These "teaching clinics" were staffed by specialists in such areas as cerebral palsy and served many children of preschool age.

The North Dakota School for the Deaf initiated an annual short-term program for preschool-age deaf children in the early 1960's. This program was also primarily an evaluation and parent training program. Another service for young deaf children and their parents was the Language Nursery at Minot State College organized in 1962. Built into the Nursery program were demonstrations for parents who learned to carry out the activities with their children. A few years later this program was expanded to include preschool age speech and language impaired children who were not hearing impaired.

North Dakota's first public school programs specifically for young handicapped children were the Bismarck Early Childhood Education Program (BECEP), providing services to three- to seven-year-old handicapped children, and the Fargo Public Schools program for four- and five-year-old handicapped children. The two programs began in 1972 and were funded through Bureau of Education for the Handicapped (BEH) grants.

In 1973, the program for young handicapped children at Southeast Mental Health and Retardation Center (now Southeast Human Service Center) in Fargo began with a grant from the First Chance Network, a Bureau of Education for the Handicapped grant program. The program served young handicapped children from birth to school age in a six-county area.

During the later 1970's, several programs for handicapped infants and preschool-age children began providing services in North Dakota communities. The Grand Forks Public Schools, South Cenpral Mental Health and Retardation Center (based in Jamestown), Northeast Mental Health and Retardation Center (based in Grand Forks), and the Minot Infant Development program were some of the programs established between 1975 and 1979.

In 1981 the Department of Public Instruction, as administrator of P.L. 89-313 funds, drew contracts with individual infant development programs for access to these funds. The contracts provided for services to handicapped infants from birth through age two when public schools provided services for handicapped children three through five years old. In public schools not serving young handicapped children, those services were provided by the infant development program as outlined in the individual contracts.

Later in 1981, a Memorandum of Understanding was developed between the North Dakota Department of Public Instruction and the State Department of Health (then state agency for infant development services) giving infant development programs

the responsibility for serving handicapped infants from birth through the age of two in situations where public schools were serving three- through five-year-old handicapped children. In areas where no public school services were available for three to five year olds, infant development would provide services to qualifying handicapped children.

With reorganization of state programs in 1982, the infant development programs came under administration of the Department of Human Services. The ten Human Services Centers in the state became the sponsoring agencies for infant development programs in their catchment areas. A Memorandum of Agreement was drawn in 1982 between the Department of Human Services, as sponsoring agency for infant development programs, and the Department of Public Instruction, as the responsible agency for supervision of each educational program for handicapped children in the state, including those administered by other public agencies (34 CFR 300.600). The agreement provided that infant development programs would continue to serve handicapped infants from birth through the age of two where public schools were serving handicapped children three through five years of age. If no public school programs were available, infant development raised the upper age limit for services to age six. In 1983 the Memorandum of Agreement was amended, but retained the basic provisions of earlier agreements.

The 1983 Legislature passed a mandate for services to handicapped children three to six years of age to be fully implemented by July 1, 1985 (NDCC 15-59-04). The mandate will have two effects: (1) those special education units or school districts that do not currently provide services to handicapped children under school age will begin to do so; and (2) those special education units providing services to young handicapped children will need to evaluate whether they are providing full services to preschool handicapped children within their respective units, and if not, will need to account for provision of full services to this population. For both special education units and infant development programs, these changes will necessitate closer working relations between the two groups as the goal of comprehensive educational services for young handicapped children is realized.

Early Childhood Education for Handicapped Children

North Dakota Regulations

(Revised 12/84)

1.0 ELIGIBILITY OF STUDENTS: Individual evaluation must include medical, psychological, social, and educational information. A multidisciplinary team must be involved in the evaluation of the individual child and in the subsequent decision of eligibility for preschool handicapped services. This evaluation information is needed in developing the individualized education program plan. See page V-48 of Guide I - Laws, Policies and Regulations for Special Education for Exceptional Children, January 1982 (hereafter referred to as Guide I) for Form SE33, Application for Preschool Students, to be submitted to the Department of Public Instruction, Special Education at the beginning of the school year for each preschool handicapped child newly enrolled in the program each school year.

1.1 Enrollees in approved programs of Early Childhood Education for the Handicapped must be diagnosed as handicapped in one of the categories used in special education and require specially designed instruction because of the handicap. This diagnosis as handicapped in one of the categories used in special education is made by the multidisciplinary team "including at least one person with knowledge in the area of suspected disability" (Guide I, Section II, Procedural Guarantees 5.1.6.7).

1.2 Children in preschool programs must be between ages three and five years when enrolled. Children must be age 3 by August 31 of the year in which they are placed in the preschool handicapped program to be eligible for services. If the child is not 3 by September 1 in a given year, the child will not be eligible for preschool handicapped services until the following year. Refer to Section 1, page 2, NDCC 15-59-01, definition of exceptional children.

2.0 APPROVAL OF PROGRAM: A request for approval must be made to the Department of Public Instruction for a program for preschool handicapped children as a part of Form SE02, Special Education for Exceptional Children Program Application.

2.1 Any handicapped preschool child enrolled in an approved program must have a diagnosed handicap to a degree constituting a severe developmental barrier. Use Form SE33, Application for Preschool Students, for each child. Submit to Department of Public Instruction.

2.2 An approved program must employ a credentialed teacher of preschool handicapped children.

3.0 SIZE OF ENROLLMENT/CASELOAD: An individualized education program may be implemented in the home or in the school. Serving children in homes with parent participation, a teacher qualified in education of preschool handicapped children may serve 3-8 children. In a school-based program, (classroom) enrollment may range from 5 to 12 children (total teacher caseload) for each teacher qualified in education of preschool handicapped children.

3.1 Consideration of the maximum number of children served by a given teacher or per session of classroom instruction should be determined by the nature and severity of the handicaps of the individual children.

3.2 Individual children's programs may require support services personnel qualified in one or more areas of special education (e.g. speech pathology, occupational therapy, physical therapy).

3.3 Staff time (teacher, support services personnel) must be allowed within the working day or week for team planning and parent consultation.

3.4 Aides may be employed dependent upon program needs. (See Guide I, Section IV, Part Q.)

4.0 PLACEMENT OF STUDENTS: The individualized education program team including the parent will review all diagnostic information and make placement decisions. See Guide I, Section II, Procedural Guarantees, 6.0.

4.1 An individualized education program may be implemented in the home, the school, or both.

4.2 The issue of least restrictive environment for three, four, and five year old handicapped children must be accounted for in the IEP process.

Least restrictive environment must be considered for five year old children where schools provide a kindergarten program. "Removal of the handicapped child from the regular education environment occurs only when the nature and severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily." (Guide I, Section II, Procedural Guarantees 6.3.2).

For young handicapped children beyond age five, exceptional circumstances (such as least restrictive environment, age appropriateness, health and medical considerations, social development) must be documented for the child to remain in the preschool handicapped program.

5.0 QUALIFICATIONS OF TEACHERS: Teachers of preschool age handicapped children must hold a North Dakota Educator's Professional Certificate and a special education credential in Early Childhood Education for the Handicapped.

5.1 Children in classroom programs must be served by a teacher holding a valid special education credential in the area of Early Childhood Education for Handicapped Children.

5.2 Teachers may receive a temporary credential in the area of teaching preschool handicapped children. The temporary credential is valid for one year and renewable up to three years. The applicant must work toward completion of the credential and fully qualify for the credential within three years.

5.3 Credential Requirements - Courses in the areas below should be at the graduate level.

5.3.1 A valid North Dakota Educator's Professional Certificate in elementary education or kindergarten education is required.

5.3.2 One Required: (Undergraduate or graduate)

Education of Exceptional Children
Psychology of Exceptional Children

5.3.3 Assessment in Preschool Handicapped Children (Graduate)

5.3.4 <u>One Required</u>: (Graduate)

Developmental Psychology
Infant Behavior and Development
Language Development and Disorders

5.3.5 <u>One Required</u>: (Graduate)

Home-School Relations
Parents, the School, Community Agencies

5.3.6 Practicum with Preschool Handicapped Children (required) (Graduate)

(Practicum or student teaching with preschool, non-handicapped children is recommended in addition but it is not required.)

5.3.7 Early Childhood Education for the Handicapped:

Introductory Course, or Characteristics of Preschool Handicapped Children
Methods and Materials in Teaching Preschool Handicapped Children
At least one other Course in the Education of Preschool Handicapped Children

or

Training in other areas of exceptionality will be reviewed. A full sequence in one area of exceptionality will be considered as an alternative to Early Childhood for the Handicapped sequence:

Introductory course for this area of exceptionality
Methods and Materials in this area of exceptionality
Practicum in this area of exceptionality
At least one other course in this area of exceptionality.

6.0 <u>FACILITIES</u>: A class for preschool age handicapped children will be in the school building and at least as large as a regular classroom, have self-contained toilet facilities, living skills areas, and meet minimum standards of heat, light, and ventilation.

6.1 Barrier-free access to the building and the classroom must account for the special needs of the young handicapped children enrolled in the program.

6.2 Safety standards applicable to young children including unbreakable furniture and toys, covered electrical outlets, tap water temperatures that are not too hot and other "childproofing" precautions as well as designated emergency procedures should be adhered to in preschool handicapped programs.

6.3 Preliminary plans for proposed preschool handicapped facilities (new or remodeled) should be sent to the Department of Public Instruction, Director of School Construction. Identify use for the space as "preschool handicapped facility/classroom."

7.0 REQUIRED INSTRUCTIONAL TIME IN PROGRAM: Any handicapped child enrolled in a preschool program must receive a minimum of eight hours of instruction per week to qualify for state foundation payment.

7.1 State per pupil foundation aid will be available when children are enrolled in an approved program for handicapped children at a rate of .49 of the state foundation payment per student.

8.0 EQUIPMENT AND MATERIALS: All educational equipment needed in the student's individualized education program must be provided.

8.1 At least three times the amount allocated for beginning a regular class will be needed to begin a special program for preschool handicapped children. For additional statements regarding equipment/materials, refer to the equipment/materials portion under the categorical handicaps of the children served in the preschool handicapped program, Guide I, Section IV, Programs and Personnel.

8.2 For ongoing programs, the expenditure allowance must be at least equal to the average per pupil expenditure for materials in the school district.

Planning a Program

Parents and professional personnel recognize the value of early intervention special education services for children of all ages, including the preschool handicapped child. Preschool handicapped children are those pupils below compulsory school age who require special education instruction and/or support services.

Rationale for Planning

A systematic approach to planning or expanding a program for preschool handicapped children will result in a program that is more effective in accomplishing its goals. The process of implementation will be smoother when preceded by sound planning.

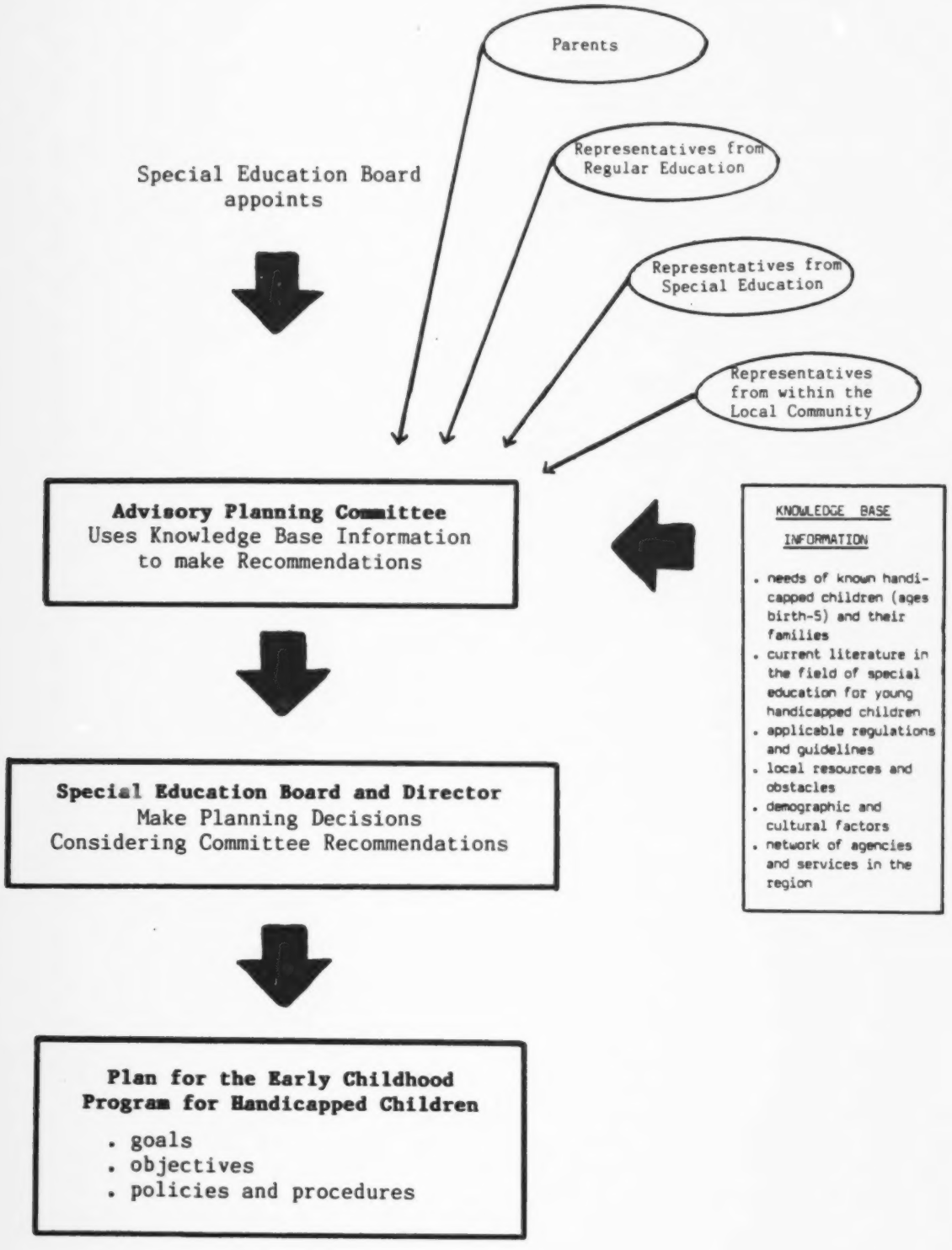
Planning will set a program on track in being responsive to the needs of young children and their families. Since a comprehensive program cannot be provided by the school alone, the planning process will facilitate the coordination of agencies whose interests lie in services to young children and families.

The Advisory Planning Committee

The vehicle for the planning process in a new or expanding program is a committee. A committee can also provide input to the staff of an existing program who want to improve services to handicapped children and their families. The advisory planning committee is appointed by the special education board and is responsible for selecting its own chairperson. The planning committee serves in an advisory capacity and makes recommendations to the special education board.

Committee members should bring certain skills to the committee. Among the committee members should be people with skills that will be needed for planning an effective program, including (1) knowledge of the needs of young children, (2) knowledge of the special needs of handicapped children and their families and options in programming for those needs, (3) knowledge of the local area, including resources as well as obstacles in serving the area. Individual committee members may have only one or may have more than one of these skills as long as the total committee accounts for all skill areas.

PLANNING THE EARLY CHILDHOOD PROGRAM FOR HANDICAPPED CHILDREN


Parents
Representatives from Regular Education
Special Education Board appoints
Representatives from Special Education
Representatives from within the Local Community
Advisory Planning Committee
Uses Knowledge Base Information to make Recommendations
KNOWLEDGE BASE INFORMATION
. needs of known handicapped children (ages birth-5) and their families
. current literature in the field of special education for young handicapped children
. applicable regulations and guidelines
. local resources and obstacles
. demographic and cultural factors
. network of agencies and services in the region
Special Education Board and Director
Make Planning Decisions
Considering Committee Recommendations
Plan for the Early Childhood Program for Handicapped Children
. goals
. objectives
. policies and procedures

The composition of the planning committee and the number of people on the committee will vary according to the needs of each special education unit. The planning committee should consist of between four and eight members representing each of the following areas:

Regular education community

Special education community

Parents

Representatives from within the community or region such as school board members, university personnel, medical personnel, or representatives of agencies.

The committee may wish to call in consultants from time to time to provide pertinent information or special expertise.

Knowledge Base

The planning committee will use a knowledge base of information that centers around the needs of known handicapped children and their families. It is recommended that this information be enhanced by current literature and research findings in the field, and regulations and guidelines that apply to preschool handicapped services, plus relevant local policies. In addition, other information that may be helpful in determining recommended courses of action to present to the special education unit's board include: (1) potential local resources and obstacles to providing services, including availablility of support services, issues in transportation, facilities and staff recruitment, and known and potential funding sources; (2) relevant demographic and cultural factors; and (3) the current network of agencies and services to young children and their families that exists within the area or region, and any possible gaps in these services.

Planning the Program

The advisory planning committee provides input to the special education director and the unit's board regarding the services needed and suggestions for how these needs might be addressed. The recommendations will be used by the director and board in making decisions about goals of the program, objectives and activities to meet those objectives, and program policies and procedures that are consistent with state and federal regulations.

Goals

Program goals should be consistent with the program philosophy and reflect the purpose of the program, and thus facilitate the planning, administration, and evaluation of the program.

Goal statements should indicate the direction and intent of accomplishments in each of these areas: services to children, services to parents, and administrative considerations.

Objectives-Development and Implementation

The program administrator will need to develop objectives for each goal statement. Objectives should be specific and measurable to facilitate the evaluation of attainment of each objective. Activities utilized to meet objectives, along with time lines for accomplishment, should also be addressed. A procedural handbook can be developed to outline the program's objectives and operating principles and serve as a reference for consideration of future problems.

Policies

Program policies are statements of a written assurance of a particular course of action and provide a systematic approach to organization. Policies should be developed "(1) to meet the requirements of state and federal agencies, (2) to provide guidelines for each of the program goals, (3) to avoid inconsistencies, (4) as a basis for decision making, and (5) to ensure fairness and protection of the program, staff, children, and parents" (Linder, 1983, page 50).

While there is always some need for flexibility within a prescribed set of policies, a clear understanding of how preschool children will be served is necessary to reduce ambiguity and to ensure that the needs of the children are met.

Ongoing Planning

A decision will have to be made related to future planning. Will the advisory planning committee continue to function as an advisory committee in long-range planning, expansion, and program evaluation? Will representation from this

committee become part of a larger special education advisory committee? Are there other options to assure that the ongoing planning and program evaluation are accounted for?

Program Services

In programs for young handicapped children, critical consideration must be given to providing the following services: assessment, educational programming, related services, parent education, family support services, transitional services, and consultation. Program staff must have competencies in each of these areas plus the ability to work effectively on a team in assessment, in planning, in day-to-day services, and in ongoing program evaluation and planning. This team effort leads to a better integrated program for the child with all personnel aware of and working toward the same objectives.

Provisions for the Least Restrictive Environment

To be sure that a child's placement will always be made in the least restrictive environment, procedures should be developed to ensure the following:

1. Alternative settings and delivery modes will need to be available so that each child's education will be appropriate to his or her individual needs. The alternatives must include whatever is needed to carry out the agreed upon individualized education program for each child enrolled in the early childhood program for handicapped children in the special education unit.

2. Safeguards to take into account in determining placement for each child include:

    a. placement is to be determined at least annually

    b. placement is to be based on the child's IEP

    c. the setting for the program is to be as close as possible to the child's home. Placement that requires that a child live away from home or that requires long distance travel daily should be planned only if there is not an equally appropriate service near the child's home.

    d. before concluding that placement be made in a special setting, all possibilities should be explored for engaging supportive services that would enable the child to receive services in a setting with children who are not handicapped. If the nature and severity of the handicap is such

that the child must be served in a setting apart from children who are not handicapped, attempts should be made to work with the family in enabling the child to interact as much as possible with nonhandicapped peers.

Service Delivery System

The choice of service delivery system is based on considerations in three areas: (1) the needs of the young children and families to be served by the program; (2) the philosophical/theoretical orientation of the local education agency, staff, and potential consumers of the program's services; and (3) the resources and constraints in the local environment.

With these three considerations in mind along with awareness of the options for service delivery described in this section, a decision can be made about the service delivery system most appropriate in a given situation. It is important to keep in mind that it is always necessary to allow some flexibility in any service delivery system so that unusual cases might be accommodated.

Models of Service Delivery

Preschool handicapped services are typically provided to eligible children through either a home-based or a center-based model or through a combination of the two. In some cases, programs for individual children may be provided in other settings such as a hospital or residential program because of the child's unique needs. Descriptions of the more commonly used service delivery options (home-based, center-based, combination home and center-based) are provided in the following sections.

Home-Based Programming

Persons supporting home-based instructional programs believe that parents can be and are the child's best teachers, that the home is a stimulating learning environment, and that the staff can perform an educational role for the entire family. In addition to the home-based philosophy, geographic and demographic considerations and health of the child can make home-based programs a more viable option than center-based programs.

The teacher providing services in the home assesses the child to determine current skill levels, helps the parent plan training activities, trains the parent to implement the activities, and monitors the parent and child's progress. As this process would indicate, home-based programming is highly dependent on parent involvement and follow-through. Shearer (1976) provides some suggestions for working with parents in home-based programs in order to gain their cooperation and commitment.

1. Set weekly curriculum goals. It is important that chosen goals can be accomplished within a week. Success for the child, and also for the parents, is critical to motivation in a program in which parents are the primary teachers.

2. Show the parent what to do and how to do it. Modeling the method of intervention is much more effective than telling the parent about it. The modeling process can also serve as an example of problem solving when the home-based teacher must modify interventions based on situational variables.

3. Have the parent practice teaching the skill. This provides an opportunity for the home teacher to spot problems quickly and increases the likelihood of the parent carrying out the activities when the teacher is not there.

4. Reinforce the parents. Breaking what may be long-established behavior patterns can be frustrating for the parents. Support and encouragement may provide the additional impetus to make changes.

5. Individualize for parents. Parents' needs and concerns will be as uniquely individual as those of their children. The extra effort required to account for parents' needs may result in greater gains for the child on several counts: improved interactions between the child and parent, greater commitment to program goals, more time and energy to spend with the child, and so on.

6. Involve the parents in the planning. As parents gain skills in working with their handicapped child, they become increasingly able to take an active role in planning their child's program. They become better able to suggest family activities in which skills can be practiced, to define goals that they have for their child, and to access resources and services that will help them realize their goals.

The caseload size and visitation schedule in home-based programs depends on the intensity of services needed by the child and family, the availability of additional support personnel providing related services, the amount of parent participation in the instructional program, and the amount of travel time. Caseloads may vary from three to eight children (Guide I, Section IV). If individual children are severely handicapped and/or have multiple needs, a smaller caseload may be necessary to adequately serve the child and family. The frequency and duration of home visits is based on the multidisciplinary team's decision regarding the amount of time that will be needed to accomplish IEP goals and objectives for a given child.

Additional support or related services can be provided either in the home or at some mutually agreeable location depending on the family/child needs. Attempts should be made to utilize existing community support services personnel such as

social workers, public health nurse, medical personnel, occupational or physical therapist, counselor, or other specialists as may be appropriate. These resource personnel may complete the diagnostic evaluation in the home or at a specified center. The specialist recommending a specific intervention can visit the home to train the parents and home teacher, to determine how the program is being carried out or how realistic the intervention recommendations are for the home setting. The recommended program may be carried out by the home-based preschool teacher and the parent with the specialist making periodic visits to evaluate the child's progress.

At least one-half day a week should be allowed for team planning, instructional planning, coordination and contacts with other agencies carried out by the home-based staff. This team planning time is essential because the home-based teacher must serve as liaison in coordinating input from parents, support services staff, other agencies, and the teacher's own observations to adjust the child's program.

An attempt should be made to involve siblings and other relatives in the child's home-based program. Involvement by others can provide respite for the primary caregivers and provide more opportunities for generalization and maintenance of the skills learned by the child.

In addition to home-based instruction, center-based services may also be provided on a weekly or monthly basis so the child can participate in group activities with other preschool children, affording the parents a variety of options such as observation in the group setting, direct volunteer teaching of small groups or individual children within the group, involvement in parent discussion, training groups, individual parent counseling, or respite care.

Advantages in delivering services to handicapped children in their homes include:

- Learning occurs in the child's natural environment; therefore, the problem of generalizing skills from school to home is ehiminated.
- Parents have direct and natural access to behaviors as they occur; therefore, functional objectives can be set and cultural considerations taken into account.
- Learned behaviors are more likely to be generalized and maintained if taught in the home by family members.
- Opportunities exist for all family members to become involved and participate in the child's program.
- In home training, parents, who are the child's natural reinforcing agents, are allowed to develop skills and confidence to deal with new behaviors as they arise.

- Individualization of the child's goals and objectives is operational since individualizing is a natural result of the setting.

- The entire family benefits because the parents apply new skills or techniques they learn to siblings.

- The preschool teacher can observe the parent-child as well as the family-child interaction.

- Home-based programming provides an alternative in rural areas where transportation to a center would be costly.

- Medically fragile children can stay home and still receive services.

Some disadvantages or limitations of the home-based program include:

- The parents are required to carry out the program and do not receive a break from caretaking.

- The programming provided in the home is not as broad as in the school-based program in that less social or instructional interaction occurs with peers.

- An effort must be made to provide the family with a strong support system.

- Supportive services such as physical therapy must be available as necessary to meet the needs of the family and child and to provide ongoing consultation to the home-based teacher. Accessing and coordinating such services may be difficult in home-based programs.

- The teacher may spend much time traveling, losing valuable teaching time.

Center-Based Programming

Proponents of center-based programming for preschool handicapped children believe that access to a range of service providers who may provide direct service to individual children and benefits from social interactions with other children are primary reasons for selection of this model of service delivery.

Services are provided in a central location generally within a school building. Transportation of children to the center/school is a major issue that must be resolved in implementing a center-based program. Related to the issue of transportation are: special concerns for medically fragile or otherwise difficult to transport children; safety and supervision considerations; the

length of a typical session; and the number of sessions per week. (See also pages to for more information on transportation issues.)

Center-based classes for the preschool handicapped can accommodate 5 to 12 children for each teacher qualified in early childhood education for handicapped children. (Guide I, Section IV). A classroom aide may be provided depending on need. Special consideration should be given to a lower caseload when severely handicapped children are being served.

The services provided to children include training across all areas of development with assistance provided from support personnel when needed. The qualified teacher of the preschool handicapped assesses the child's needs, provides instruction, supervises classroom aides, and monitors the child's performance.

In addition to center-based instruction, a component of services to the family is often provided. Family services may include home visits or may consist of activities for family members provided at the center such as family support services (e.g. parent or sibling support groups), family education programs, or family involvement in the center-based sessions.

At least one-half day per week should be allotted for team planning, instructional planning, agency contacts, and other coordination activities to be carried out by the preschool staff. When responsibilities are divided among staff members team planning is essential in facilitating communication, monitoring, and making decisions on needed changes.

Advantages of school-based programs are:

- A wide range of services may be available, including services to the family.
- All families have a common setting for their children, who are allowed access to a variety of toys and materials that may not be found at home.
- Children are exposed to other children and thus have an opportunity to develop social skills important to their total development.
- Children may have an opportunity for individual therapy. Children's programs may also have input from many disciplines.
- Children have a chance to learn to interact with adults other than their parents.
- Parents have a chance to observe and perhaps work with children other than their own.
- Parents may have an opportunity to talk to other parents and share feelings and experiences, thereby gaining emotional support.

- Parents may need time away from their handicapped child; the school time allows them some respite.
- Time is used more efficiently when staff members are not driving from house to house.
- Team members can work more closely when they are centrally based.

The disadvantages of the school-based program relate to:

- The cost of providing transportation for the children to attend the program may be substantial.
- Family involvement is usually less than in home-based instruction.
- Transfer of demonstrated teaching activities is not easily made from the school to the home.
- Preschool staff may lack knowledge regarding the home environment and plan activities inappropriate for home.
- Natural reinforcers available at home are not readily apparent at school.

Combination Home-and Center-Based Programming

Because of the needs of individual children, some programs may opt to provide both center-based and home-based programming in their system of service delivery. For example, through individualized education plan (IEP) development it may be determined that a few medically fragile or severely handicapped children require home-based services while several moderately handicapped children would be most appropriately served in a center-based program.

Another example of a combination of service delivery systems might be a program decision that all three-year-olds and older medically fragile children would receive home-based services while the majority of handicapped four- and five-year-olds would be served in a center-based setting. In some situations, the individualized education planning (IEP) team may decide to provide home-based programming as an option to one or two children during certain months of the year (e.g., winter when some children are highly susceptible to respiratory problems) while otherwise providing center-based services.

Single Service Only

If the multidisciplinary evaluation team determines that a speech impaired child requires services in the area of speech, the IEP team must explore whether the speech impairment has affected the child's educational needs to the extent that placement in a preschool program for handicapped children is required. If the team determines that educational interventions are not required, but that speech services are needed for purposes of speech correction, arrangements can be made for the child to receive speech services in a designated center or in the home or consultation services may be provided for the parents.

In addition to this direct service, parent training groups may be initiated by support services staff to assist parents in working effectively with their child and to encourage independence from support personnel. For example, parent training groups have been used effectively for teaching parents techniques to correct articulation, improve syntax or other mild language-related problems in the home.

When occupational therapy or physical therapy are recommended as related services, such services cannot be provided until the IEP team explores how the identified needs affect the child's learning and educational performance. By definition, related services are those services which are required in order for a handicapped child to benefit from special education services. A child requiring educational interventions because of a handicap may also require related services such as occupational therapy or physical therapy in order to benefit from special education services.

Supplementary Service Delivery Options

Consultation

Consultation services may be required in several circumstances. The first of these is consultation to the preschool program staff when expertise beyond that available in the program is required to meet the needs of individual handicapped children. The multidisciplinary team may decide that consultation from a specialist is warranted in a particular child's case. The specialist would review records, determine if additional evaluation is needed, conduct such evaluation, and make recommendations to and answers questions from the multidisciplinary team. The specialist would also provide training to the staff and family in carrying out specific recommendations.

Some children may be served by regular education staff or by other agencies or programs. It may be necessary for the preschool staff to provide consulting

assistance to parents, to other programs into which young handicapped children may be placed (for example, a handicapped child who is mainstreamed or one who is dually placed in the preschool program for handicapped children and in Headstart), or to agencies or individual service providers.

Other services consultants can provide to staff and parents include: supplemental exercises and activities that can be incorporated into the child's day to maximize the child's performance level; recommending, designing, and/or making special adaptive equipment for use at home and school; providing inservice training, demonstrations, and workshops to parents and/or staff members as needed; and providing the staff and parent with specific management techniques for a child with multiple handicaps to enhance the child's performance level.

One of the disadvantages of the consultant model is the reliance on the program staff and the family to carry out the intervention. Time must be regularly scheduled for the consultant to observe the program and meet with the family and program staff to adjust the intervention accordingly.

Technology-Based Options

In some areas where transportation is a major obstacle to the delivery of direct services, consideration can be given to alternative forms of information sharing.

Media-based options include utilizing closed circuit television to transmit training and technical information and self-contained instructional packages designed for use by parents or paraprofessionals. Video tapes may be employed to provide information on child development and management techniques or on assessing and teaching techniques when consultants are not available. Likewise, computers have been used in rural areas for assessment and teaching. A checklist of skills is sent to the family and other community-based personnel such as a public health nurse or social agency representative and they administer the checklist. The information gained from the checklist is programmed into a computer which delineates those skills that should be targeted. Video tapes are then mailed out for use in teaching the targeted skills. WATS telephone lines and special frequency radios can also serve as communication links to provide consultative skills to remote areas.

In some rural communities, mobile resource centers provide assessment and instructional services. Assessment teams consisting of multidisciplinary staff in coordination with various local community agencies travel from one rural community to another providing needed assessments. The mobile unit can also be fitted as a classroom to conduct classes in the morning while the afternoons are spent working with parents and children in the home. Toy lending and parent/child take-home libraries are also incorporated into the mobile unit.

Transitional Arrangements

Some three year olds entering preschool programs for handicapped children have been identified as handicapped and have received services through infant development programs. These children and their families go through a process of transition as they leave one program and enter another. Likewise, when preschool handicapped children reach age five or six, they will make the transition into other programs for school-aged children.

These two transitional phases require some special arrangements and services to the young handicapped child and the family. In the first instance, infant development programs through the Developmental Disabilities Case (D/D) Management System take the responsibility for notifying the school's preschool program of any three year old handicapped children who will make the transition. The Developmental Disabilities (D/D) Case Manager will also prepare the family for the transition and set up meetings between the family and personnel from the sending and receiving programs. Through the teaming process, personnel in the school's preschool program for handicapped children have responsibility for providing information about the school program to the family and infant development staff members. This may include setting up visits to the preschool program and offering opportunities for infant development personnel and the parents to visit with school staff members. After the child begins receiving services in the preschool program, staff members in the two programs may want to continue communication regarding the child. It is suggested that this be done through the Developmental Disabilities (D/D) Case Manager since D/D Case Management will follow the child throughout his or her years in school and beyond.

Special arrangements also need to be made for five and six year olds as they exit the preschool program for other school programs. Careful planning and preparation for the upcoming transition should begin well in advance of the change from one program to another. This is especially true when the child will enter a situation that is substantially different from the preschool program for handicapped children, such as a regular education kindergarten program. It is important to involve parents in planning for transition. They can assist in preparing the child for the change and will provide much valuable information to the multidisciplinary team made up of personnel from both the sending and receiving programs. Inviting parents to visit the receiving program may help them to understand expectations in the new situation and will allow them to become familiar with staff members and routines. See pages to of this guide for transition checklists for administrators, parents, receiving teachers, and sending teachers.

Before planning the transition, it is important that preschool personnel have identified the similarities and differences between the preschool program and the receiving program (either self-contained special class or regular education classroom). This may include interviews and exchange visits between sending and receiving programs. An analysis of the discrepancies between the two programs

can then become the basis for "training for transition" as the child approaches the end of his/her time in the preschool program. For example, if the child is to enter a kindergarten program, the training might involve teaching the child ways to solicit the teacher's attention, weaning the child from consistant praise not available in a large group setting, or preparing the child to work independently while sitting at a desk (Fowler, 1981).

Follow-up activities to the transition may include consultation from preschool staff members as the child adjusts to the new situation. Data collection might continue after the child has made the transition to provide input for evaluation of the preschool program's effectiveness or for longitudinal research purposes.

Services to Families

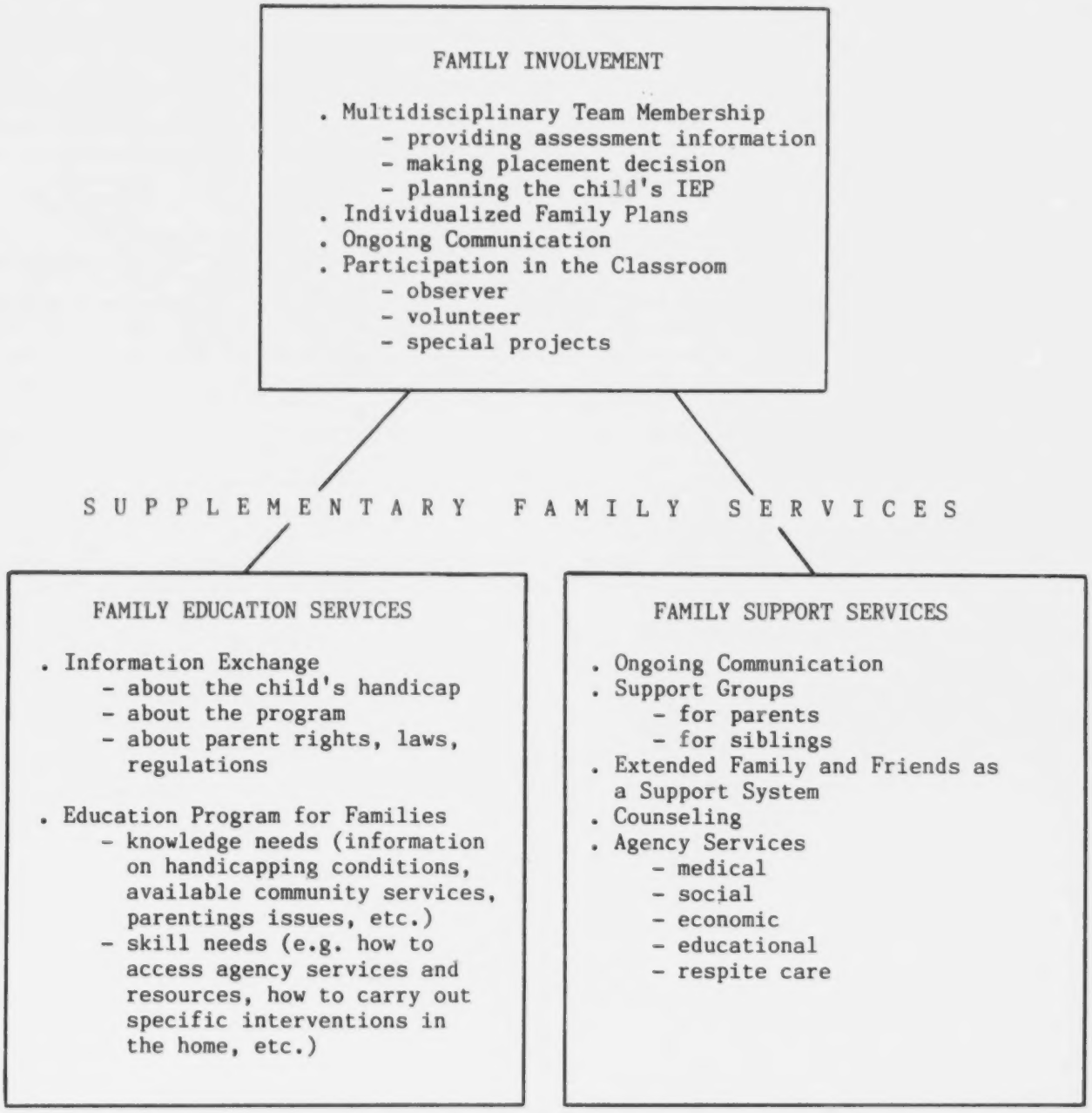
Regardless of the service delivery model selected, family involvement is critical to the successful education of the preschool handicapped child. Parent involvement in the handicapped child's educational program is mandated by P.L. 94-142, but beyond this, family involvement is only reasonable when considering the needs of preschool children, especially those who happen to be handicapped. Parents and siblings have provided and will continue to provide for the handicapped child's needs before, during, and after the child's placement in the preschool program for handicapped children. Bronfenbrenner (1975) noted that evidence indicates that "the family is both the most effective and economical system for fostering the development of the child" (page 470). This is true in that (1) family members are the primary teachers during the child's first years of life and (2) interventions by family members occur in the natural environment and across settings in that environment, thus improving chances that learning will generalize.

The goal of family involvement is to establish regular and frequent communication between the home and the program and to offer parents varied opportunities to acquire skills, knowledge, and techniques to better understand and cope with the needs of their child. With this goal in mind early childhood special education personnel can develop a family services component that addresses child and family needs.

Family Involvement

P.L. 94-142 guarantees parent participation in decision making regarding placement and programming for the handicapped child. This basic level of involvement assures parents the right to participate in the multidisciplinary team decision making regarding the child's eligibility for special education services and in development of the child's individualized education plan (IEP). This involvement begins with the first contacts made to the family either by the referring source (e.g. a physician or agency personnel) or by the program staff once a referral is received. Sensitivity and support on the part of professionals at this time can set the tone for an effective and successful program for the child as well as a positive working relationship with the family. Family involvement throughout the assessment process can enhance the family's participation in the multidisciplinary team's decision making regarding the child's eligibility for services. The parents are in the best position to clarify for staff members whether assessment results are typical patterns of behavior, to give information about medical or other relevant factors in the child's development, and to provide other observations of the child not available to the staff in assessment situations.

SERVICES TO FAMILIES


FAMILY INVOLVEMENT
. Multidisciplinary Team Membership
- providing assessment information
- making placement decision
- planning the child's IEP
. Individualized Family Plans
. Ongoing Communication
. Participation in the Classroom
- observer
- volunteer
- special projects
SUPPLEMENTARY FAMILY SERVICES
FAMILY EDUCATION SERVICES
. Information Exchange
- about the child's handicap
- about the program
- about parent rights, laws, regulations
. Education Program for Families
- knowledge needs (information on handicapping conditions, available community services, parentings issues, etc.)
- skill needs (e.g. how to access agency services and resources, how to carry out specific interventions in the home, etc.)
FAMILY SUPPORT SERVICES
. Ongoing Communication
. Support Groups
- for parents
- for siblings
. Extended Family and Friends as a Support System
. Counseling
. Agency Services
- medical
- social
- economic
- educational
- respite care

In the development of the child's individualized education plan (IEP), parents and other family members can provide input on priority targets for programming, assist in determining methods that might work, suggest interventions to be carried out in the home, or provide information on motivational, health, and social-emotional variables.

In addition to planning for the child's individual needs, plans for individual families may be developed in the IEP planning process based on the family's goals and needs. An individualized plan for a family's involvement should incorporate the unique needs of the family and recognize that the family's role is central to the child's development. An individualized plan for the family may involve goals that relate to the handicapped child and also goals that relate to the family's meeting other needs. For example, a family's goals might be (1) to integrate an intervention into the family's daily routine, such as reinforcing language and fine motor skills while bathing the child; (2) to access resources in order to obtain an alternative communication system for their child; (3) to find a more rewarding part-time job for the mother; or (4) to enroll siblings in a workshop on play with a handicapped brother or sister.

An important aspect of family involvement is ongoing communication. Achieving ongoing communication is somewhat easier in programs that are home-based or have a home visit component because communication is built into the program; however, center-based situations can implement traveling notebooks (the parent writes notes to the teacher and vice versa as the child carries the notebook to and from the program), telephone calls, and frequent conferences (both formal and informal). Ongoing communication is critical for young children whose physical health may be unstable or who undergo rapid developmental changes that necessitate program changes. In center-based settings family involvement in the child's program may also be encouraged through parent participation in the classroom as observers or volunteers, or as assistants in special projects such as fund raising.

Supplementary Options in Family Services

The information presented in the previous section included a discussion of basic levels of family involvement in the young handicapped child's educational program. Programs may provide two additional levels of service to families through their own resources or families may access these services through other agencies. The two optional levels are family education and family support services.

Family education provides information that addresses the families' knowledge and skill needs. Information directed at families' knowledge needs might cover topics such as various handicapping conditions, available community resources, parenting issues, organizations for parents of handicapped children, and so on. Skill needs topics might address how to access agency services and resources, how to carry out specific interventions in the home, how to set up a trust fund for the handicapped child, or how to manage specific behaviors.

Knowledgeable parents may act as resources to other parents as they share their own experiences and what they have learned about having a handicapped child.

The second type of supplemental service, family support services, may be provided as part of the program's family services component or may be accessed through other agencies or programs. Ongoing communication, as previously described, provides a basic level of support to families. In addition, family support may be provided through support groups for family members (e.g. siblings, parents, or grandparents), through the natural support system of extended family members and friends, through counseling services, or through agency services (i.e. medical, social, economic, or educational services or respite care).

Guidelines for Family Services

The addition of a handicapped child to a family has a significant impact on the entire interactional system of the family. Consideration of some basic guidelines in serving families can enhance the quality of services provided to the handicapped child and the family, and facilitate communication between the program staff and the family.

In communicating with a family, professionals need to listen and support the family members, keeping in mind that families may react in different ways at different times. They must be sensitive to the parents' fluctuating emotions and responses regarding their child.

There are many societal expectations and pressures on the family to raise their handicapped child to conform to cultural patterns. The culturally different family may require special support as they face systems that do not acknowledge these differences.

Parents may appear disinterested, overprotective, rejecting, or guilt ridden, but it is extremely important that professionals reserve judgments until they have a clear understanding of situations, especially when economic or cultural factors distinguish parents from professionals. Making assumptions may get in the way of communication and development of a trust relationship between the family and professionals. Parents can often sense that they are being negatively evaluated even though this is not communicated verbally.

Professionals need to communicate clearly using everyday language. Parents should be encouraged to check their perceptions of what is being conveyed and to ask questions when something is unclear. Parents need time and assistance in understanding the significance of information presented to them by professionals.

The families' specific knowledge about their child should be solicited and utilized. Families should be involved in assessing the child's strengths, in setting goals and determining intervention methods, and in evaluating success.

The extended family and immediate community can be educated about handicapping conditions through printed materials, media, support groups, or agency programs. Encouraging extended family members and friends to offer practical and emotional support can help families of handicapped children reduce social isolation.

Staffing Patterns

After the nature of the population and services needed have been established, the staff required to provide those services must be determined. A number of options exist in staffing patterns. Some of the typical roles and responsibilities of the most commonly included staff positions in programs are described in the following sections.

The development of job descriptions that reflect the services needed and the program philosophy will help to ensure that responsibilities of various staff members are clear, so disagreements and misunderstandings are avoided.

Staff hired to provide needed services must be "qualified" as determined by the state educational agency (34 CFR 300.12). The qualifications for special education personnel in North Dakota are listed in Guide I - Laws, Policies, and Regulations for Special Education for Exceptional Students, Section IV, Special Education Programs and Personnel.

The roles and responsibilities of the special education director/program coordinator, teacher of preschool age handicapped children, related services personnel (speech/language pathologist, occupational and physical therapist, psychologist and social worker), aides and volunteers in the program for preschool handicapped children are listed in the sections that follow.

Special Education Director/Program Coordinator

Depending on the structure of the local special education unit, the director and/or program coordinator will need to make decisions regarding administrative responsibility for the program for preschool handicapped children. Some responsibilities may be delegated to or shared with other professionals. For example, the director will need to establish how special education and regular education administrative responsibilities will interface if the center-based program is located in a school building.

Roles and Responsibilities of Special Education Director/Program Coordinator:

- Develop program components such as the service delivery system, family involvement component, staffing pattern, identification system, staff development system, etc.
- Develop program policies and procedures.
- Supervise and coordinate program implementation.
- Develop and manage budget.

- Evaluate program effectiveness.
- Act as community/interagency liaison.
- Supervise and hire staff.
- Manage recordkeeping/documentation systems.
- Insure that provisions of state and federal regulations are carried out.
- Insure that materials, equipment, and other resources necessary for program implementation are available.

Teacher of Preschool Age Handicapped Children

Roles and Responsibilities:

- Screening and assessment of referred children including documentation of results.
- Development and implementation of program services to children and to families.
- Team participation and planning including training team members (related services personnel, parents, aides).
- Consultation to program staff and to other programs such as Headstart or kindergarten.
- Knowledge of child development, handicapping conditions, working with parents, regulations and guidelines that apply to serving young handicapped children.
- Coordination of children's programs, parent involvement, team planning.
- Recordkeeping and documentation.

Related Services Personnel

Federal regulations describe related services as "transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education and includes speech pathology and audiology, psychological services, physical and occupational

Related Services Personnel

Roles and Responsibilities

General Roles and Responsibilities of Related Service Personnel

- Screening and assessment of referred children including documentation of results.
- Team participation and planning including training team members (teacher, parents, aides).
- Assist in development of individualized education plans and implement or train others to implement the child's program.
- Consult with parents and other team members or other programs such as Headstart on the child's program, the child's progress, or other concerns.
- Knowledge of child development, handicapping conditions, working with families, and regulations and guidelines that apply to serving young handicapped children.
- Recordkeeping and documentation.
- Determine need for special adaptive equipment, assist in design and/or acquisition of equipment such as alternate communication systems or prosthetic devices, and train others in using specialized materials.

Additional Roles and Responsibilities of Physical Therapist and Occupational Therapist

- Physical Therapist can assess: (1) gait; (2) reflex; (3) posture; (4) mobility; (5) developmental level of gross motor abilities; (6) muscle strength; (7) range of motion testing; (8) use of adaptive equipment, positioning, lifting, and transfer techniques and mode of mobility.
- Occupational Therapist can assess: (1) eye-hand coordination; (2) hand function; (3) muscle strength; (4) developmental level of fine motor abilities; (5) oral/feeding; (6) sensory assessment; (7) visual perception; (8) range of motion; (9) use of adaptive equipment, positioning, lifting and transfer techniques, and mode of mobility.
- Provide the parent and preschool staff with facilitative positioning to enable the child maximum benefit from the activities occurring in the classroom.
- Advise parents and preschool staff in the selection and use of play equipment, chairs, prone boards, and bolsters.

Additional Roles and Responsibilities of the Speech/Language Pathologist

- Assess receptive and expressive communication behavior. This includes assuming responsibility for either providing or arranging for appropriate audiological services such as puretone, impedance, or brain-stem hearing assessments.
- Help parents establish communication with their child by instructing them as to the developmental level at which the child can communicate and communication skills appropriate to that level.

Additional Roles and Responsibilities of the School Psychologist/ Psychological Services

- Administer and interpret psychological tests. May administer a test of general intellectual ability and use the standardized situation to focus on the child's response to the social aspects of the situation. May utilize play techniques in assessment, behavioral assessment, achievement testing, or adaptive behavior assessment.
- Provide information through testing and clinical impressions regarding the specific disability of the child and integrate input with the findings of other professionals and the parent's observations.
- Relate the characteristics of the child to those of the family and previous experience.
- Act as a liaison to other psychological services in situations where indepth clinical psychological assessment and treatment are indicated.

Additional Roles and Responsibilities of the Social Worker *

- Assess family's needs and strengths.
- Provide group or individual conseling for development of effective parenting or alleviation of family problems.
- Initiate contacts with appropriate agencies to locate and obtain resources needed by the preschool handicapped child and family.
- Explore family's attitudes toward their child's handicapping condition and capabilities and help them set appropriate expectations.
- Provide support for the handicapped child's siblings directly or through the parents.

* If no social work services are available, these roles and responsibilities must be carried out by other members of the team

therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training" (34 CFR 300.13a).

Related services personnel are part of the multidisciplinary team who evaluate the child in their areas of specialization and assist in planning the child's program. General roles and responsibilities of related services personnel are listed on page 36 along with additional responsibilities unique to each area for those related services most frequently utilized: occupational therapy, physical therapy, speech/language pathology, social work services, and psychological services.

If related services are not available through the local education agency or special education unit, they may be provided through contractual arrangements with other public and private agencies within the community. See Section IV of North Dakota Guide I for qualifications of related services personnel working in special education.

Aides

An aide may be necessary when additional instructional time beyond what the preschool teacher is able to provide is required for children enrolled in the preschool handicapped program. An individual child with very specific needs that require a highly individualized program may also necessitate the addition of an aide to the classroom. The aide would assist in the implementation of appropriate individualized programs to meet the special needs of individual children.

Roles and Responsibilities:

- Carry out instructions for children's programs or provide teacher support as designated by supervisor.
- Provide to supervisor observational information obtained while carrying out assigned activities.
- Assist in child management.
- Recordkeeping/data collection as prescribed.
- Team participation and effective communication with team members.

Volunteers

In a center-based program, volunteers may be utilized as additional aides in the classroom. They require the same inservice and training procedures as aides although the intensity will vary with the role they assume in the classroom. Potential volunteers include parents, high school students, senior citizens, university or college students who may or may not be practicum students, or members of community service organizations or religious groups.

Volunteers may assume some of the same responsibilities as aides or they may choose a nonteaching task such as construction of materials, organizing field trips, or raising money for special projects such as purchasing new equipment for the classroom.

Staff Development

It is the responsibility of the special education director/program coordinator to account for the staff development needs of program personnel.

The primary purposes of staff development are to change attitudes, increase knowledge, and improve performance and interpersonal skills. Staff development as an integral part of a preschool handicapped program can provide (1) supplementary training to enable preschool personnel to acquire additional background and skills; (2) ongoing information on new research developments that will provide more effective services; (3) increased skill among paraprofessionals, parents, and volunteers who work directly with children. Where staff members bring diverging philosophies to the program, staff training can assist in developing program consistancy, reduced tension, and increased communication.

Identification of Competencies

The knowledge, attitudes, and skills needed by the preschool program staff should be identified as competencies. Underlying this identification are the philosophy and goals of the program along with expert opinions from professionals involved in preschool education of the handicapped, evaluative data from parents and program supervisors regarding attitudes and skills that contribute to a successful program, and research on successful methods and practices in preschool education of the handicapped (Linder, 1983). Along with the competencies identified, inservice training for parents and staff members involved with preschool education of handicapped children should consider (1) the noncategorical approach to serving children; (2) the wide range of

ability levels among children; (3) a need for multidisciplinary teaming; (4) training to work with families as well as children; and (5) training to work with interagency networks and systems.

Assessment of Staff and Parent Needs and Interests

Inservice activities are most meaningful when the parents or staff members are involved in identifying their own needs and interests. Various methods for assessing staff needs and interests may include interviews, questionnaires, or observations. Interviews can provide information on the background, experience, training, interests, and a self-evaluation of skills for each staff member. Questionnaires allow parents or staff members to express their interest in specific training areas. Observations of professionals' performance provide a competency check to determine strengths and weaknesses. A competency checklist allows each skill to be rated by the level of skill needed: awareness, working knowledge, or functional expertise.

Inservice Training Plan

After staff needs and interests have been assessed, priorities for individual or group training should be selected by the administrative staff interacting with the preschool staff and/or parents. After the priorities have been targeted, the best methods for accomplishing the objectives of the inservice training can be determined and timelines tentatively planned.

Areas targeted for inservice should be those that have been identified as important for development of an effective program as well as those rated high as needs by the staff or parents. The timelines could address those areas requiring training at different points of the year by focusing first on those areas that may be more vital at the beginning of the program.

In a multidisciplinary program, not all staff members or parents require the same level of competence in each competency area. The levels are awareness, working knowledge, functional expertise, and enrichment. Providing varied levels of learning individualizes staff development.

Seminars, lectures, courses, conferences, discussion groups, simulations, demonstrations, and workshops provide basic, current information to develop awareness and working knowledge of a topic. By including follow-up activities to provide feedback, coaching, and reinforcement to the staff members, staff development alternatives can provide experiences that develop the needed expertise. Examples of follow-up activities could include: (1) related readings; (2) observing others perform a skill; (3) simulating the activity; (4) keeping a journal of the results in applying the newly-learned skill in the classroom; (5) direct consultation in the classroom; (6) videotaping staff and reviewing the tapes (7) practicing the skill with feedback and coaching from other staff members.

Staff exchanges or other on-the-job training experiences can also provide opportunities for immediate feedback. For those staff members with a high level of expertise in most areas, conducting workshops, planning conferences, and assisting with staff development can provide means for continual growth and professional development.

Including an evaluation component in staff develoment activities will assist in determining the effectiveness of the planned activities. This information can also be helpful in planning future programs. (See also Evaluation on pages 48 to 50.)

Administrative Considerations

As a program for preschool handicapped children is planned, a number of decisions relating to program administration must be made. Some of these decisions are based on options that the program administrator has selected. Choices in service delivery and staffing patterns dictate needs for classroom facilities (if a school-based service delivery model is selected), transportation (of children for a school-based model or staff for a home-based model), and funding. Needs of children to be served must be considered as decisions are made regarding emergency procedures necessary in serving young handicapped children. The sections that follow -- Classroom Facilities, Emergency Precautions, Interagency Collaboration, Transportation, Funding, and Evaluation -- address considerations in making administrative decisions.

Classroom Facilities

A school-based class for preschool age handicapped children will be in a school building and in a room at least as large as a regular classroom, have self-contained toilet facilities, living skills areas, and meet minimum standards of heat, light, and ventilation (Special Education in ND: Guide I - Laws, Policies, and Regulations. Section IV, page 43).

Preliminary plans for proposed facilities for preschool handicapped children (new or remodeled) should be sent to the Department of Public Instruction, Director of School Construction. The plans will be reviewed to determine compliance with the American National Standards Institute (ANSI) specifications for making buildings and facilities accessible to and useable by the handicapped. Adherence to the ANSI specifications will ensure compliance with the regulations of Section 504 of the Rehabilitation Act of 1973 that addresses discrimination of persons on the basis of handicaps through the inaccessibility of a facility to a handicapped person. (Director of School Construction, North Dakota Department of Public Instruction, July, 1984)

An accessibility checklist developed by Brooks & Deen (1981) is applicable for facilities serving both adults and children and draws heavily from the ANSI standards. Some of the key considerations addressed that refer specifically to the preschool handicapped population are identified below.

Ramps should have a handrail 32 inches above the ramp surface for adults and a lower set appropriate to the size of the children served.

Stairs should have two sets of handrails available on each side of the stairs at a height of 32 inches for adults and at an appropriate lower height for children.

- Water fountains should be accessible to handicapped preschoolers at a height of 26 inches from the floor.

- The heights of toilet seats should be appropriate for orthopedically handicapped preschoolers at 12 to 17 3/4 inches.

- The heights of the sinks should be 29-34 inches from the floor to accommodate orthopedically handicapped preschoolers.

- Pull-up bars should be located near the toilet and sink for handicapped children.

- A towel dispenser or hand dryer should be located beside each sink no higher than 30 inches from the floor.

Other considerations in designing a barrier-free classroom for the education of preschool handicapped children include: (1) well-lighted corridors and classrooms; (2) location away from loud noises, excessive odor, or heavy traffic; (3) no free-standing columns or pipes blocking access to any part of the room that would decrease the mobility of visually impaired children; (4) no permanent structures that could prevent auditory impaired children from seeing the teacher from all parts of the classroom; (5) adjacent play area, drinking fountains, and sinks; (6) direct access to bus loading/unloading or parent drop-off areas; (7) location of the preschool classroom near other age-related classrooms to control unstructured interactions between older and younger students; (8) carpeted areas where children will be participating in floor activities; and (9) a nonslip floor surface that will not impede the locomotion of a physically handicapped child in a wheelchair in traffic areas within the classroom. (Brooks and Deen, 1981.)

Safety Standards

Certain "childproofing" precautions should be adhered to in the classroom: (1) covered electrical outlets; (2) cleaning products stored in locked cabinets; (3) tap water not hot enough to scald children; (4) furniture free of protrusions and stabilized to prevent toppling; (5) furniture resistant to scratching, chipping, or staining; (6) furniture of the appropriate height, that is functional and comfortable; (7) flooring in areas used for toileting, eating, or art activities should be of a dense resilient material resistant to damage by toileting, accidents, and spillage of food, paint, and water; and (8) appropriate use of hard surface versus carpet flooring for children with physical handicaps. (Washington Department of Public Instruction, Guidelines for Preschool Programs for Handicapped Children in the State of Washington, 1980.)

Additional information on classroom facilities is provided in the Appendix section Classroom Organization, pages 78 to 85.

Playground Facilities

The playground facilities for the preschool handicapped child should be located adjacent to the preschool classroom to facilitate an easy transition in and out of the school building. Adaptive playground equipment may be necessary for some children. For example, adaptive swings, a hammock, or a rubberized cement ramp leading up to a low-pitched and high-sided slide may be appropriate (Streifel and Cadez, 1983).

Emergency Precautions

Fire or Other Emergencies

In case of fire or other emergencies, an evacuation plan should be developed and practiced to ensure the safe exit of each handicapped child and staff member. Staff members could be assigned certain children to guide out of the building.

Local, state, and federal fire codes and guidelines have provisions for emergency exits. Locating the classroom for the preschool handicapped children adjacent to these emergency exists can facilitate a safe and efficient exit by minimizing the travel time to the outdoors. Fire alarms and extinguishers should be near the classroom and the emergency number should be posted on each phone. (Washington Department of Public Instruction, 1980)

Medical Emergencies

The medical records of each child should be kept current and should include the name and telephone number of the family's health care professional, emergency numbers of the parents and neighbors, and restrictions of food, activity level, medication, or positioning that may be relevant for the child. When services are being provided to children with health-related problems, a phone in the classroom may be a necessity.

The telephone number of the ambulance or emergency medical personnel should be posted by each telephone. A well-stocked first aid kit and books on first aid emergencies should be kept in the classroom. At least one member of the staff should have had training in first aid, cardio-pulmonary resuscitation, and seizure management.

A written policy of emergency procedures for children and staff in the classroom should be posted. Prior arrangements should be in place for another adult to be

available momentarily should the teacher need to accompany a child to emergency care. Likewise, a routine should be established for emergency care, whether by ambulance or other predetermined means. These precautions are of greater importance with regard to the medically fragile child who may be served in a school-based program. The building principals should also be knowledgeable of the situation. (Washington Department of Public Instruction, 1980.)

Dispensing Medication

Written policies and procedures for dispensing medication at school should be made available for all staff. The medicine should be sent to school in the original bottle with the name of the doctor, the name of the child, the exact dosage, and name of medication. This information is essential to prevent accidental poisoning. Medication should always be kept in a locked cabinet or drawer and out of children's reach. Each medication given to a child should be promptly recorded by the individual who provided it for the child. (Washington Department of Public Instruction, 1980.)

Other Health Considerations

Each child should have on file a health and developmental history completed as part of the assessment process. An ongoing record such as the Problem-Oriented Medical Record (POMR) can be a beneficial tool to both assessment and programming for those children whose physical health is an ongoing concern. See the North Dakota Department of Public Instruction publication, Procedures to Guarantee an Individualized Education Plan by Ida Schmitt, 1978, pages 113-117, for a detailed description of POMR.

Immunizations must be up to date prior to attendance in a school-based program. Exemptions may be granted by a physician for medical reasons or the parents of the child may file a religious exemption.

The staff should be aware of any children with food allergies or dietary restrictions and provide food at each child's developmental level to chew and swallow.

Special positioning or programming should be utilized with those children with physical limitations. Children with a heart condition should be restricted from strenuous play; children with cerebral palsy require special positioning to benefit from some classroom activities; some physically handicapped children require transferring from their wheelchair; and blind children should not sit facing the sun.

Classroom sanitation requires a diapering area and facilities for safe disposal of soiled diapers. The diapering area should be sanitized between uses. Each child should have a complete change of clothing marked with his or her name. Children should be instructed to wash their hands after toileting.

Infectious illness. Parents of children with heart or respiratory weaknesses should be informed when someone in the classroom has an infectious illness.

Interagency Collaboration

Interagency collaboration refers to efforts on the part of separate service providers to work together to share ideas, information, and resources. The broad goal underlying such collaborative efforts is improvement of COMPREHENSIVE service delivery to the population served, including improved access to services, greater consistancy in services, and better coordination of services. No single agency provides services for all needs -- health, economic, social, education -- so interagency collaboration and cooperation become vital when a child and family require more than one type of service.

Another issue addressed by interagency collaboration is fragmentation of services. This is particularly true where there may be duplications in services or gaps where no service is currently available to meet identified needs. The current economic and social climate of declining resources along with increased social advocacy for providing new or expanded services has put many agencies in the difficult position of determining how to continue to provide or expand services with fewer financial resources. Interagency collaborative efforts can assist agencies as they address fragmentation while maximizing resources in light of current economic and social pressures.

Special education administrators can serve a key role by facilitating collaboration between the school and other agencies serving young handicapped children. This is true because most of the identified young handicapped children will have educational needs while, the child-family needs for health, social services or economic assistance will vary with the situation. Since other agencies will often make first contacts with families of handicapped children, they can serve as major referral sources to school programs indicating the need for a close working relationship. The special education administrator can identify those agencies likely to have contact with young handicapped children, establish contacts with key personnel, and inform the agency of referral procedures.

A logical starting point for collaboration among agencies is location and identification of children needing services. A major goal of agencies working

together is to see that children are identified and referred to appropriate agency services. This matching process can be facilitated when agencies (including the school) are aware of one another's services and referral procedures. The process can be further enhanced when agencies share responsibilities for location, identification, or evaluation through cooperative financial and/or personnel sharing arrangements. An example of such cooperation is a joint screening program in which several agencies contribute financial and personnel resources and use the resulting information to channel referrals to appropriate agencies.

Some administrators may choose to initiate an interagency council that brings together representatives from several agencies to deal with common concerns. A council has the advantage of providing broader input for decision making along with the advantage of doing so on a face-to-face basis. At first topics may concentrate on identification or services to individual children, but may eventually address more complex issues such as gaps or duplications in services.

Other issues for collaboration include cooperative inservice training, sharing personnel, facilitating smooth transitions as children move from one agency's program to another, or developing contracts between agencies for certain components of services. Agencies may at some point be ready to draw up interagency agreements that define the responsibilities of each agency as well as points for cooperation between the agencies.

Transportation

If transportation is a related service as determined by the IEP planning team, the school district of the child's residence and the special education unit in which the district participates are responsible for arranging and providing transportation (or boarding care in lieu of transportation) for handicapped students who must be transported or live away from home in order to receive special education (North Dakota Century Code 15-59-02.1).

The district of residence may use any reasonably prudent and safe means of transportation at its disposal. Such means may include, but are not limited to, a regularly scheduled school bus or transportation provided by a handicapped child's parent or other responsible party at school district expense (ND Guide I, 1982).

Special precautions need to be considered when transporting young handicapped children, making transportation provided by a parent or other responsible adult a more viable solution in some situations. Lengthy rides, adequacy of supervision, and safety and comfort for the child must be considered. Often carpools can be arranged among the parents of the children in a preschool classroom. The number of children transported at a given time should be based on safety and supervision considerations. Children should ride in car seats when appropriate or wear safety belts. North Dakota Century Code 39-21-42.2 requires that such restraint devices be used for children up to four years of age when the passenger vehicle is operated by the child's parent. The adult

should escort the children into the classroom when dropping them off and return to the classroom to pick them up. This will control accidents that may occur if children are left to cross a street by themselves or enter the school building unattended.

If handicapped preschoolers ride a bus, the child's handicapping condition should be considered in determining the length of the bus ride. Another adult in addition to the bus driver should ride the bus to supervise the children. A separate bus may be used to transport preschool children to minimize unstructured physical interactions with older children that might result in injury.

Individual handicapping conditions need to be considered in determining the type of vehicle most appropriate for transporting a child. The vehicle transporting children in wheelchairs, for example, must be equipped with fastening devices that hold wheelchairs in a secure and fixed position. Children may also be transferred in and out of wheelchairs if they are able to sit well-balanced on a regular bus seat. Such considerations will require that a bus driver be given training in the handling and positioning of physically handicapped children.

The North Dakota Safety Council has prepared a training unit for school bus drivers on transporting handicapped children. The unit deals with problems a driver may face such as handling health or behavior problems, handling seizures, communicating with a handicapped child. The unit is available from county superintendents. A videotape used in the training unit is available from the North Dakota Safety Council (223-6372) or from the Department of Public Instruction's Director of Finance and Reorganization (224-2267).

The reader is also referred to a resource document by Dr. Linda Fran Bluth titled Transporting Handicapped Students: A Resource Manual and Recommended Guidelines for School Transportation and Special Education Personnel (1985). The document is available from the National Association of State Directors of Special Education (NASDSE), 2021 K Street, N.W., Suite 315, Washington, D.C. 20006 at a cost of $6.00.

The vehicles providing transportation for handicapped preschoolers should be equipped with a two-way radio and special emergency equipment such as a first aid kit, blankets, or flares.

Funding

Special education programs in public schools are funded through a combination of federal, state, and local outlays. The federal funds come from two channels. Entitlement programs such as P.L. 89-313 or P.L. 94-142 are distributed according to the number of children enrolled in the special education program. Funds flow through the state education agency to the local education agency. Preschool Incentive Grants are another entitlement program that may provide extra dollars for each preschool handicapped program. The amount of the entitlement varies from year to year, depending upon fiscal authorization from

Congress. The second channel of federal funds is available through application for grants that can be awarded to the state or local education agency.

An additional revenue source is provided by the state. North Dakota Century Code, Section 15-59-06, provides state per pupil foundation aid that is available when children are enrolled in an approved program for preschool handicapped children at a rate of .49 of the state foundation payment per school-age pupil. State special education funds also provide reimbursement to programs qualifying for program approval.

Section 15-59-08 of the North Dakota Century Code allows school districts to levy a tax for special education. These local funds pay excess costs in providing special education services to all handicapped children within the local district or unit.

Evaluation

Ongoing planning and evaluation are crucial components of a program for preschool handicapped children. As a program is implemented situations will arise that were not accounted for in the original planning process. The administrator and members of the program staff are responsible for developing problem solving procedures that may be used when such situations arise.

In addition to ongoing problem solving and subsequent changes in planning, personnel responsible for the preschool handicapped program need to evaluate the effectiveness of the program. Programs are evaluated to determine strengths, deficiencies, gaps, and duplications in services to handicapped children and their families. Linder (1983, page 218) quotes Renzulli (1975) in identifying the specific purposes of program evaluation:

- To discover whether and how effectively the objectives of a program are being fulfilled.
- To discover unplanned and unexpected consequences that are resulting from particular program practices.
- To determine the underlying policies and related activities that contribute to success or failure in particular areas.
- To provide continuous in-process feedback at intermediate stages throughout the course of the program.
- To suggest realistic, as well as ideal, alternative courses of action for program modification.

The effectiveness of the program is determined through an assessment of which services are provided, how services are provided, at what frequency (and duration) they are provided, and the quality of the services provided. Quality is the broadest of these issues and is determined by analyzing the child

progress data, parent satisfaction, skills of individual staff members, the program's responsiveness to needs of the children and families served, the program's ability to identify and provide for unmet needs, the program's functioning as part of the interagency network of services to young children and families, and compliance with regulations. In addition, quality of the program relates to whether current services are overlooking any areas of concern or whether an inordinate amount of time or energy is being expended in some areas at the expense of a balanced or comprehensive program. For example, is the program so heavily weighted towards pre-academic, cognitive, and language development that attention to development in other areas -- motor, independence/self-help, or socialization -- is short-changed in the process?

What to Evaluate

The answer to this question must be preceded by answers to two other questions: "Why evaluate?" and "Who will use the results?" The why and who answers will help to focus the evaluation, making it easier to determine what should be evaluated. If the reason for the evaluation is, for example, to determine the effectiveness of the parent education component of the program and the results will be used by the staff and parents to plan future programs, the evaluation will focus on the staff's and parents' reactions to previous attempts at parent education and perceived needs in this area. By contrast, the question "what to evaluate?" has a very different answer if 1.) the reason for the evaluation is to determine whether or not the current staffing pattern should be changed to better meet the needs of the children enrolled, and 2.) the results will be used by administrative personnel to make staffing changes, if indicated. In this case, child progress data, parent satisfaction, amount of child contact time of various staff members, skills of staff members in particular areas, the team process currently employed, and identified unmet needs are some of the areas that may be evaluated to obtain relevant information for decision making.

In general, any of the objectives of the program may be evaluated. Services to children, services to parents, administrative considerations, or specific components of these areas as described in previous sections of this guide may be targeted for evaluation. If program personnel are new to the area of program evaluation, they may want to begin on a small scale evaluating a single component such as the effectiveness of the screening program or staff development before undertaking evaluation of broader areas such as the system of Child Find, staffing patterns, or services to children.

How to Evaluate

Information may be gathered in many different ways. As in "What to Evaluate?", the methods chosen should relate to the reasons for the evaluation and who will use the results. The specifics of what is to be evaluated often suggest use of some types of information gathering methods over others. For example, since no

formal evaluation instruments exist for determining the impact of interagency involvement on the program, a survey would need to be developed. Such a survey would likely be superior to a formal instrument, were one available, since a program-established survey can be geared to particulars of the program and the agencies involved.

Some of the many ways evaluation information can be gathered include established instruments such as tests, checklists, and rating scales, instruments constructed specifically for the evaluation, interviews, anecdotal records, observations, ongoing program documentation such as daily logs and graphs or progress reports, or statistical data.

Evaluations may be conducted by any group or individual interested in the effectiveness of the program, including parents, administrators, program staff, research centers, and other agencies, etc., though most of the impetus will likely be from program and administrative staff. Self or peer evaluation by staff members can provide much valuable information on the program's effectiveness if such evaluation is honestly engaged in and does not become a rubber stamp for current practices. At times an outside evaluator with special expertise may be called on to assist with program evaluation. An example might be calling in a consultant to evaluate the use of augmentative communication systems developed for three multihandicapped children in the program or might entail a broader evaluation of team functioning.

In summary, taking evaluation of the program's effectiveness beyond a round table discussion may be unfamiliar to program staff. For some issues, such as determining room arrangement, the round table discussion is probably adequate. For other issues, such as evaluation of children's progress in the program or effectiveness of the parent education component of the program, a discussion will not give adequate information for making decisions about needed changes. Other types of evaluation, as described in this section, are necessary.

Identification and Programming for Young Handicapped Children

Identification and programming for young handicapped children is a process that includes (1) locating and identifying those children with risk factors for a handicapping condition, (2) assessing the children individually to determine if they are handicapped and whether they need specially designed instruction, and (3) designing a program aimed at meeting the child's unique needs.

The first part of the identification process is commonly called "Child Find" and encompasses public awareness efforts, the referral process, and screening programs. The assessment phase includes criteria for eligibility and those procedures prior to, during, and following the individual assessment that determine if the child is handicapped and in need of services. The assessment will also provide information that is useful to establishing the child's educational program, such as skill levels for beginning instruction, attention span, social and emotional factors which affect learning and areas of interest. For the handicapped child in need of specially designed instruction, the individualized education planning team will pull together all information about the child and use this information to determine the child's unique needs. The child's program can then be planned to address these areas of need.

The three phases of the identification and programming process are described more fully in the following sections on Child Find, Assessment, and Programming.

Child Find

The term "Child Find" refers to the entire system of procedures aimed at locating and identifying children who are in need of special services. The goal of the Child Find System is generation of referrals from individuals or agencies who are aware of children needing services. Child Find Systems encompass the age range 0 through 21, though most of the previously unidentified children entering the Child Find System each year are in the early childhood (0-5) age range.

Responsibility for Child Find is shared by federal, state, and local education agencies as well as any other agency providing services to young handicapped children. Even though these activities are shared, the final and legal responsibility lies with the local and state education agencies.

The Child Find System encompasses all efforts aimed at identification of handicapped children including public awareness/education, development of referral procedures and screening programs, and building an interagency network. Public education is a prerequisite to all other identification efforts.

Child Find is an ongoing process that operates day by day and is not just a once or twice a year effort on the part of local special education units. The day-to-day contacts that school personnel have with parents, agency representatives, or the public may provide ongoing reminders that services are available. Potential for locating unidentified handicapped children is maximized through all public awareness and interagency collaborative efforts whether these efforts be formal or informal.

September Child Find Efforts

Certain times during the year may be designated for special recognition of the Child Find System, as is the case during the third week in September when the Department of Public Instruction coordinates activities with local special education units in publicizing Child Find. The designation of Child Find Week gives special education units the opportunity to enlarge on public education within their local areas. Some of the publicity vehicles include newspaper announcements and articles, local radio station interview programs and announcements, public speaking opportunities, brochures, posters, and give-away advertising items such as balloons, pens, and placemats.

Other Child Find Efforts

Another example of special recognition given to Child Find is the preschool screening program sponsored by local special education units that frequently occurs during the spring of the year.

Public Education

Ongoing public awareness or education is critical to the success of Child Find procedures. Potential referral sources such as parents, physicians, and agencies will make appropriate referrals only if they are aware of existing programs. Public awareness will also enhance turnouts for screening programs and will aide in building interagency cooperation.

To effectively locate all handicapped children in the school district, the local education agency (LEA) must increase the level of awareness in the general public and in other agencies regarding:

Early warning signs that should result in referral.

The importance of early intervention.

The availability of existing programs and services.

Parent and child rights under state and federal laws.

Referral procedures for suspected handicapped children to appropriate programs.

(Washington Department of Public Instruction, Guidelines for Preschool Programs for Handicapped Children in the State of Washington, 1980)

Activities aimed at increasing public awareness of preschool handicapped services and other services for handicapped children may take many forms. A wide variety of printed media formats may be used including flyers, brochures, posters, and newspaper articles. Radio and television stations may broadcast public service announcements describing Child Find or may provide longer public information programs describing identification procedures, early warning signs, and so on. Public speaking engagements with civic clubs, teacher and parent groups, and businesses and other organizations also provide a unique opportunity to build public awareness of the importance of early identification and intervention.

Since awareness must be ongoing if all handicapped children are to be identified as early as possible, a key to sustained public awareness is periodic presentation of the program's goals.

Careful planning and evaluation of public awareness and education efforts will help to build an effective Child Find System. Periodic reviews of the procedures will help to uncover inconsistencies. This information can then be used to refine the Child Find System.

The next two sections dealing with referrals and screening procedures are important parts of the Child Find System and are perhaps the most significant means of locating children potentially in need of services.

Referrals

To generate appropriate referrals, potential referral sources must be informed about the program. Such information may include written and verbal communications that relate to the education program's goals, target populations to be served, specific referral procedures, identification of contact persons, and delineation of what may be expected from the educational program once a referral is received as well as what is expected from the agency making the referral.

Although the programs and agencies within any given area or community will vary, information sharing regarding the program's services should be provided to any and all who may serve as potential referral sources to education programs. A sample listing of agencies with whom information might be shared follows:

1. County public health or social services departments.
2. Local medical personnel in clinics and hospitals.
3. Regional services such as the Developmental Disabilities Case Management System or Protection and Advocacy.
4. Other community organizations with a special interest in young handicapped children.
5. Head Start agencies, public and private schools, day care centers.
6. Parent groups or voluntary organizations.
7. College or university evaluation and intervention programs.
8. Other public and private agencies serving the handicapped.

Referral Procedure

The referral procedure includes (1) identifying the contact person or persons to whom referrals will be channeled, (2) defining the specific types of information to be obtained at the time of referral, and (3) determining policies that apply to record sharing and to the system of follow-up and feedback to the referral source.

Screening

Screening is the process of looking at children with the goal of determining whether the children may have risk factors for handicapping conditions. Those children whose handicaps are readily identifiable will likely be referred to programs by physicians, by parents or family members, by infant development programs, or other agencies. For many other children whose handicaps are less easily recognized, developmental screenings are the primary means of identification.

Screening is a relatively quick, inexpensive procedure for determining which children evidence characteristics that would place them at risk for possible handicapping conditions. Screening is not diagnostic. It will <u>not</u> determine if a child is handicapped. What screening will do is establish that certain "indicators" of risk for a handicapping condition are present. The indicators will be that the child appears to have a significant delay in one or more areas of development. The indicators of risk become the basis for referring the child for in-depth assessment.

Some screening procedures are devised to screen children in a particular geographic area. Notices about the screening program may be mailed to parents of young children and/or announced through the media. Children and parents come to a centralized location where the screening is conducted. Entire day care centers, Head Start programs, or kindergarten classes can also be quickly and effectively screened for children potentially in need of services. Screening may also be conducted after receipt of a referral. The referred child is screened to determine if there is a need for in-depth assessment.

Areas of development covered in comprehensive screening programs include all or some of the following:

- Family and developmental background information.
- Vision and hearing.
- General physical health.
- Gross and fine motor skills.
- Speech, receptive and expressive language.
- Cognitive skills and level of conceptual development.
- Self-help skills.
- Personal-social skills.
- Pre-academic skills.

The instruments and procedures used to screen children in the areas listed above may be commercially developed screening tools or may be locally developed. The formats may range from interviews with parents to tasks the child performs while a professional observes. Screening instruments should be evaluated to determine if they are appropriate for screening and whether each of the screened areas provides sufficient information. (A listing of commercially produced screening measures is provided in Appendix E on pages 104 to 108.)

Screenings may be conducted by the school or by agencies, or may be a joint effort on the part of the school and other agencies. Joint efforts at screening are a form of interagency collaboration. The personnel who conduct the screening may be professionals with specific or general expertise in early childhood development or may be trained volunteers. Professionals involved may be nurses, early childhood or preschool handicapped teachers, speech/language pathologists, occupational or physical therapists, psychologists, social workers, audiologists, or administrative personnel.

Successful screening programs require planning and coordination. Chazron, Harvey and McNulty (1978) have suggested a planning process that includes the following activities:

1. Outline goals of the screening program. If the screening is to be a joint effort on the part of several agencies, this must be a joint planning session.

2. Designate responsibilities and establish commitments.

3. Utilize existing screening programs. Discuss and agree on joint methods and procedures.

4. Define the population to be screened, including the geographic location to be covered, age range, approximate numbers of children, whether transportation will be provided, and whether child care for siblings will be provided.

5. Determine the developmental areas to be screened (e.g., motor, vision, cognitive, self-help, etc.).

6. Determine screening instruments/procedures to be used.

7. Establish screening sites.

8. Arrange dates and times for screening.

9. Publicize all relevant information so that other agencies are aware of it.

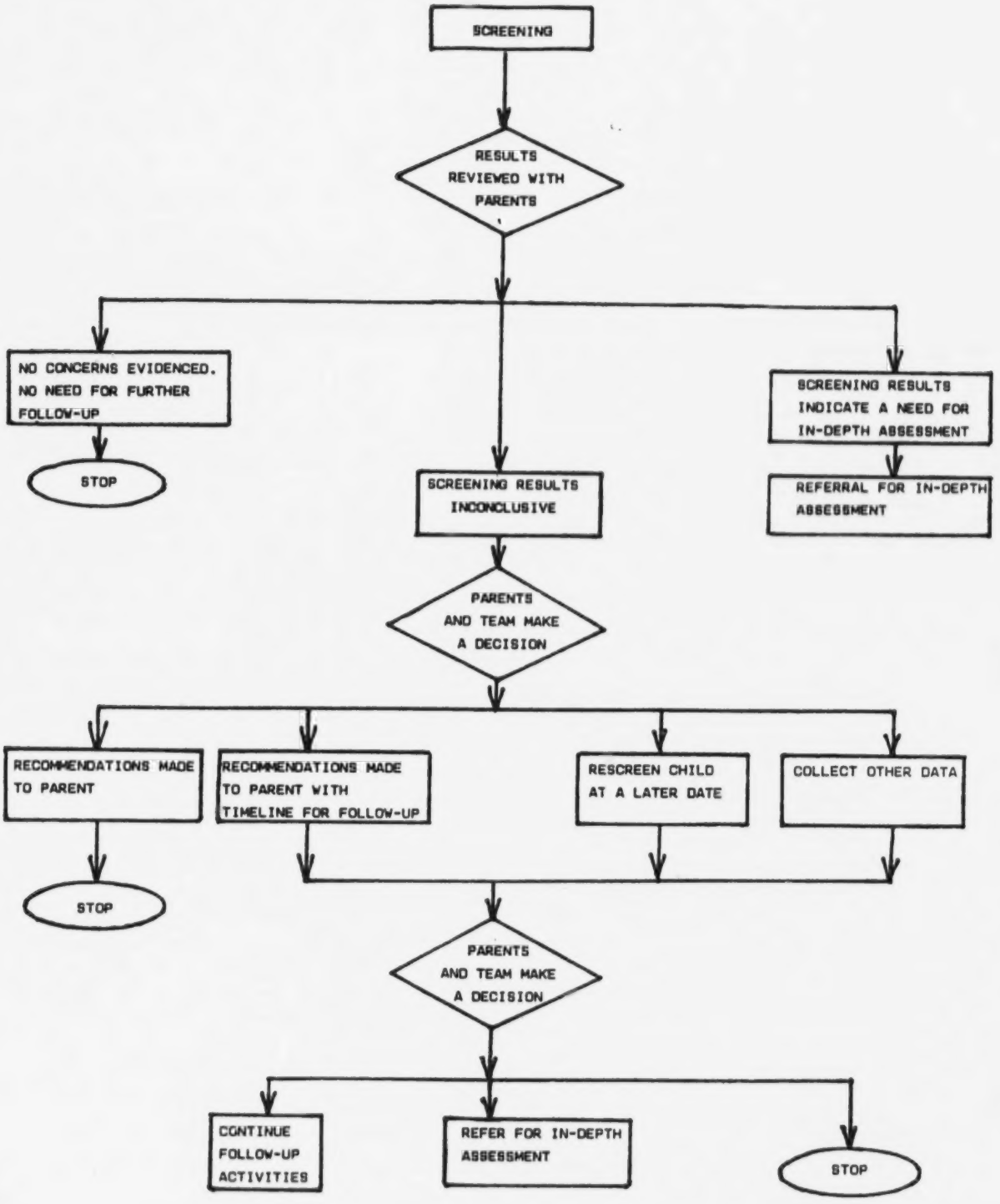
10. Determine how the community and parents will be notified of the screening. Plan a comprehensive public awareness campaign.

11. Determine the actual screening process from collecting intake information on the child to summarization of the screening results and follow-up procedures.

12. Plan for the training of screening staff.

Following the screening, information about the child will be reviewed by the team. Parents are typically provided with a verbal and written summary of the results. Children screened fall into three groups. Parents may be informed that the screening evidenced no concerns and there is no need for further contact. The second group of screening results show a need for further attention, but what is needed is not clear. In this case, the screening team and the parents will need to determine which of the following options is most appropriate: (1) to set a length of time before re-screening the child; (2) to make recommendations to the parents; (3) to make recommendations to the parents and set a time for follow-up; or (4) to identify other data which are required before making a decision. In making a decision regarding follow-up action, the team can gain valuable information if parents are given the opportunity to make comments and ask questions. Documentation of the recommendation along with any timelines for follow-up is very important for monitoring and future planning.

FOLLOW-UP TO SCREENING


SCREENING
RESULTS REVIEWED WITH PARENTS
NO CONCERNS EVIDENCED. NO NEED FOR FURTHER FOLLOW-UP
STOP
SCREENING RESULTS INCONCLUSIVE
SCREENING RESULTS INDICATE A NEED FOR IN-DEPTH ASSESSMENT
REFERRAL FOR IN-DEPTH ASSESSMENT
PARENTS AND TEAM MAKE A DECISION
RECOMMENDATIONS MADE TO PARENT
STOP
RECOMMENDATIONS MADE TO PARENT WITH TIMELINE FOR FOLLOW-UP
RESCREEN CHILD AT A LATER DATE
COLLECT OTHER DATA
PARENTS AND TEAM MAKE A DECISION
CONTINUE FOLLOW-UP ACTIVITIES
REFER FOR IN-DEPTH ASSESSMENT
STOP

The third type of screening results will indicate a need for in-depth assessment. Special care should be taken in summarizing results and making recommendations to parents in this meeting since it may be their first real indication that the child may have a handicapping condition. It is critical that sufficient time be allowed for parents to ask questions and make comments. Parents should be provided with information on what is being recommended: the specific type of assessment recommended, who will perform the assessment, where the assessment will be done, costs (if any), options that exist for assessment, what will happen after the assessment, and parental rights related to the recommendation.

Follow-up Procedures

Procedures implemented following screenings must be given careful consideration. If the results of screening are to be used to the fullest advantage, responsibility for case management must be assigned, recordkeeping and monitoring procedures must be established, and information must be provided to parents and agencies. Parents of children referred for assessment may require continued support throughout the procedures following referral.

Eligibility

According to North Dakota Guide I - Laws, Policies, and Regulations for Special Education for Exceptional Children, children are eligible for early education programs for handicapped children if they have been "diagnosed as handicapped in one of the categories used in special education" and require specially designed instruction. See Section IV of Guide I for criteria in each of the areas of handicapping conditions or other Department of Public Instruction guides in each handicapping area. Children must also be "between ages 3 and 5 years when enrolled." Three year olds must be age 3 by August 31 of the year in which they are enrolled.

The categories used in special education as outlined in P.L. 94-142 (34 CFR 300.5) are:

- deaf
- deaf-blind
- hard of hearing
- mentally handicapped
- multihandicapped
- orthopedically handicapped
- other health impaired
- seriously emotionally disturbed
- specific learning disabled
- speech impaired
- visually handicapped

North Dakota programs providing services for young handicapped children may be organized on a categorical (single categorical handicapping condition such as hearing impairment) or multicategorical basis (several handicapping conditions served by the teacher of preschool handicapped children). In either type of program, teachers must meet qualifications for a credential in the area of Early Childhood Education of Handicapped Children.

The Assessment Process

P.L. 94-142 mandates that a comprehensive evaluation of the child's individual educational needs must be conducted before a child is placed in a special education program (34 CFR 300.531). The materials and procedures used in the assessment must be nondiscriminatory, appropriate to the developmental level of the child, and must be multifaceted. A multidisciplinary team assessment is necessary to ensure a comprehensive evaluation of the child's total needs. Each assessment team member contributes specific knowledge and expertise in gathering information regarding the child's current functioning levels, including strengths as well as weaknesses in developmental areas.

Planning the Assessment

Developing an assessment plan prior to evaluating children for possible special education services will ensure a comprehensive evaluation. An assessment plan is designed to provide each child with an individualized evaluation based on the child's unique needs.

An assessment plan helps determine specific assessment needs by pinpointing specific areas to assess, helps alleviate duplication of prior assessments and previously gathered information regarding the child, determines the most appropriate procedures for gathering further information and thus assures the assessment process will be time efficient and well organized.

Steps in the assessment planning include:

1. Review the assessment process and procedural safeguards with the parents.

2. Obtain written consent for the evaluation from the parents.

3. Obtain written consent from parents for release of information regarding their child from any outside agency or source that would be pertinent to the assessment or to educational planning, such as medical information from private clinics and agencies.

4. Gather all information known about the child (such as information from parents regarding the child's background and history, information from the referring source, information from screening, information from any existing school records and any other information previously collected). The parent will offer much valuable information regarding their child including developmental information and behavior across settings (home, community, day-care, and others).

5. Based on the information currently known, determine more specifically with parents the assessment information that needs to be gathered, who will gather the information, and what assessment procedures will be used.

The Assessment Team

The multidisciplinary assessment team must include the parents. The parents are important and necessary members of the team because they offer crucial information about their child's skills and needs. The team must also include at least one teacher or specialist in the area of the child's suspected disability [34 CFR 300.532(3e)]. Often the teacher of preschool handicapped children serves in this role. Other team members may need to be added to provide the necessary comprehensive assessment. Team membership may include but is not limited to the following:

Teacher of Preschool Handicapped Children.

The teacher of preschool handicapped children has knowledge of child development and is able to assess several areas of development including fine motor skills, perceptual skills, play behavior, and cognitive skills, offering a comprehensive assessment of the child's growth and learning patterns.

Consultants in specific areas of handicapping condition.

The speech/language pathologist or specialists in hearing, vision, emotional disturbance, mentally handicapped, specific learning disabled, orthopedically handicapped or severely/multiply handicapped may conduct assessments in their areas of specialization.

Related service specialists (occupational therapist, physical therapist, social worker, adaptive equipment specialist, and others).

The child's regular classroom teacher.

The child's teacher offers much pertinent information regarding the child's level of functioning, areas of learning problems, educational strategies that work or that do not work, and information on peer and adult relationships. A classroom teacher (such as kindergarten or nursery school teacher) can also be used as an observer of the child's skills and reactions in a group setting for the child who has had no other "school" experience.

A medical specialist (school nurse, physician, eye specialist, and others).

A child's health status and medical needs must be assessed. For example, the effects of medications for seizure disorders or hyperactivity must be assessed and monitored or a determination must be made of the physical stamina of other health impaired children.

The referring source.

The referring source may offer pertinent information such as background information previously collected on the child, screening data, information regarding family dynamics, indications of the suspected area of disability, or names of other sources or agencies with information regarding the child.

For some severely handicapped children, a wide array of evaluation procedures needs to be carried out. So that a total picture of the child's functioning is obtained, it is critical that the assessments not be carried out in individual segments. Instead, a team of two or more evaluators may assess the child's responses at the same time, but from the perspective of their own specialization. It may be necessary to carry out the comprehensive evaluation at a special center such as a children's hospital or rehabilitation unit where all evaluation procedures are integrated.

These special evaluations may be necessary at any time throughout the child's programming. This is particularly true for children who may have health impairments such as seizure disorders, hyperactivity, kidney dysfunction, and so on.

Areas of Assessment

"The child is assessed in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities" [34 CFR 300.532(3f)]. For young children suspected to have a handicapping condition, the assessment may also include such areas as pre-academic and cognitive functioning, self-care and other adaptive skills, or critical elements of the child-family situation.

Assessment Procedures

The individual child assessment must be comprehensive. No single procedure can be used as the sole criterion for placement of the child in a program for handicapped children [34 CFR 300.532(3d)]. A comprehensive assessment is

ensured through use of a variety of procedures such as observations, interviews, standardized tests, criterion referenced tests or diagnostic inventories, developmental checklists or scales, or adaptive behavior measures.

The assessment procedures used must be non-discriminatory, accounting for the child's native language or mode of communication and the nature of the child's impairment. Test instruments must be validated for the purpose for which they are used and must be administered by trained personnel (34 CFR 300.532). Appendix D (pages 98 to 103) provides a listing of some test instruments commonly used in programs for young handicapped children.

Formal or standardized tests should be chosen for appropriate reliability and validity. These tests provide a comparison of the child's skills to those of the normative population and give a quantitative description (typically a percentile or age equivalent) of this comparison. If possible, standardized instruments should be normed on the group for whom the test is being used. A controlled environment is necessary when standardized test instruments are being used.

Informal measures (such as criterion-referenced tests or checklists) provide information that supports and expands on more formalized testing data. Informal measures provide specific information on the child's current level of functioning, including skill strengths and weaknesses. These measures may also provide information on concommitant factors to the child's learning such as attention span, preference for certain learning modes (e.g. hands-on and seeing rather than listening), interest areas, or activity level.

Some of the most valuable assessment information about the young child can be provided by the family and others familiar with the child, since they have observed the child in a variety of environmental settings (home, child-care settings, social settings). Family members will also be aware of the child's developmental and medical history. Pulling together the observations, both past and current, of those familiar with the child will contribute to the understanding of the child's functioning over time and across settings. This will help to give the broader view of the child so necessary in making decisions about the child's needs.

For assessment purposes, it is also possible for the child to attend either a regular classroom (such as nursery school or kindergarten) or the preschool handicapped classroom for a few days to gather assessment information through observation of the child in a group setting. The information gathered from informal tests and observations in this setting along with interviews of staff members and parents will help to provide a more global view of the child's skills and needs.

Summarizing Assessment Results

A collaborative summary of all assessment findings must be discussed and written by the multidisciplinary team following completion of the assessment process.

While individual team members may write reports of their own findings, the collaborative summary must pull together and integrate all relevant information about the child's functioning. The summarizing process should also serve to reconcile discrepancies in the findings through explanation, interpretation, or by calling for additional evaluation. The team's summary information should provide the necessary evidence to establish:

Whether the child is eligible for special education and/or related services.

Determination of the child's eligibility for services requires answers to two questions: (1) Is the child handicapped? (2) Does the child require specially designed instruction because of the handicap? The team draws conclusions from the assessment results as to whether the child is handicapped and, if so, the nature and extent of the handicapping condition as well as the child's unique needs. A child may meet the criteria for a handicapping condition, but because of the nature and extent of the condition, may not require special education services.

The child's current level of performance.

Results and conclusions determined by consensus of the assessment team will be used by the individualized education planning (IEP) team to define the child's present level of functioning, including strengths and weaknesses, interferences to learning, and readiness for instruction.

Possible further assessment needs.

Since assessment is an ongoing process, further evaluations may be necessary at any point in time based on changes in the child or on previously unrecognized areas of need. For example, the IEP team may determine that other information is needed before particular areas can be addressed in goals and objectives or an IEP review meeting may raise serious questions about changes in the child's physical health that seem to warrant an updated medical evaluation.

It is typical that assessment results are shared at a multidisciplinary team meeting. This allows team members, including the parents, to check perceptions about the child, to integrate the findings, and to reconcile any discrepancies with the input from all team members. The parents serve a major role at this time since they are in a far better position than other team members to ascertain whether assessment results are typical behavior for the child, to determine whether other relevant factors may have affected results, or to provide observations of the child in situations not available to the evaluators that may help to clarify team findings.

The assessment summary information should also be shared with all members of the IEP team before program planning in order to give team members an opportunity to

review the information, to formulate possible questions, and to individually explore options or alternatives for the most appropriate program for the child.

The Individualized Education Plan

Developing the individualized education plan (IEP) is a process of problem-solving and decision-making that assures appropriate educational programming designed to meet the unique needs of the handicapped child. The IEP process helps to assure that a quality program is developed for the child, assures parental participation, and provides for programming accountability (34 CFR 300.345-349).

A multidisciplinary team is involved in the problem solving/decision making process of planning the child's IEP (34 CFR 300.343-344). The team effort provides a sharing of various skills and expertise, helping to assure a total service plan and quality programming. P.L. 94-142 requires that the IEP be documented as a statement of the child's educational program that serves as a basis for day-to-day planning.

Parent Involvement

The parents must be invited to participate in the development of the IEP just as they are in any placement and planning decisions for their child. They are able to share much valuable information regarding their child's skills and needs. Parents who are involved in planning efforts are more apt to understand and are in a better position to follow through with their roles and responsibilities regarding their child's program.

The parents must be given notice as to the time, location, and purpose of the IEP meeting and who will be in attendance. The meeting must be scheduled at a mutually agreeable time, and must be scheduled with enough advance notice to insure parent participation.

If the parent cannot attend the meeting, it may be necessary to use other methods such as a conference call to conduct the meeting. The school must document any and all attempts or efforts to insure parent participation, including detailed records of telephone calls and the results of those calls, copies of any correspondence sent to the parents and their responses to the notice, and detailed records of home visits or visits to the parents' place of employment and the results of the visits (34 CFR 300.345).

Even if the parents choose not to attend the IEP meeting, it is suggested that the parents be provided a copy of the child's written IEP.

The special education unit should encourage parents to be active members of the IEP team. Providing them with a copy of the IEP agenda in advance would be beneficial. Preparing a guide that helps parents understand the program

planning process also may help parents in taking a more active role.

An IEP meeting must be scheduled and a plan written no later than 30 calendar days after the child has been assessed as needing a specially designed instructional program (34 CFR 300.343).

IEP Team Membership

The members of the multidisciplinary IEP team must include (34 CFR 300.344):

An administrator or designee who is qualified to provide or supervise the provision of special education. The administrator is able to commit school resources and services and is knowledgeable about other resources within the community or region and other pertinent issues related to school commitment.

The child's teacher. If the child was not in a school program prior to this time, a teacher qualified to teach preschool-age children should be assigned to the team. If the child's placement is likely to change from one program into another, both the sending and receiving teachers should attend, if possible.

The parents. Parental participation is encouraged in the IEP process as in all planning and decision making steps. The parents can and do offer insight into the child's skill levels, learning styles, and needs, and their input and suggestions are helpful in planning an appropriate program.

An assessment team member or person knowledgeable of the assessment results is a required IEP team member in the case of an initial assessment. This individual can assist in accurate interpretation of assessment findings and conclusions.

The child, when appropriate.

Other individuals at the discretion of the parent or the school.

Many preschool handicapped children have multiple handicaps requiring a variety of services. When related services such as occupational or physical therapy are required for a child, the expertise of these individuals is crucial to the team's planning an appropriate program. For example, when a severely involved orthopedically handicapped child is to be placed in a program, the teacher will need to learn proper positioning and handling for that particular child. The expertise of the physical therapist and/or occupational therapist is required

not only to determine what techniques are appropriate for the child, but also to assist the teacher in applying the techniques to the classroom setting.

Content of the IEP Document

The ultimate goal of the placement and programming process for the preschool handicapped child is to determine the most appropriate program placement in the least restrictive environment. The IEP must reflect a total service plan in meeting the child's entire educational needs.

The information obtained from the multidisciplinary team assessment will be used as a part of the IEP process. This includes information regarding the nature and extent of the handicapping condition that helps in determining the type, amount, and nature of services that the child will receive. It is the child's unique need for specially designed instruction that differentiates one child's program from that of another child. For example, a hearing impaired child will need a very different type of program and services than that of an orthopedically impaired child.

The format of the IEP document may vary from one program to another as long as the essential elements are included. It is strongly recommended that accurate documentation is ensured for future reference, including complete dates and full names of persons involved as well as their positions.

The IEP document must include (34 CFR 300.346):

- A statement of the child's present levels of educational performance;
- A statement of annual goals, including short-term instructional objectives;
- A statement of the specific special education and related services to be provided to the child and the extent to which the child will be able to participate in regular educational programs;
- The projected dates for initiation of services and the anticipated duration of the services;
- Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short-term instructional objectives are being achieved.

It is the responsibility of each public school district to develop and monitor any IEP for each handicapped child regardless of placement, whether it be in a public, private, parochial, or a residential school (34 CFR 300.341, 347, 348).

Any development, review, and/or revising of an IEP must be done by a team. The review process will ensure that the child's program is based on a consensus of opinions, knowledge, and skills of several people rather than a few, that the decisions are a result of the problem-solving process and are made by a team, and that the end result will be the most appropriate program reflecting a global or total service plan for the handicapped child.

Consideration must be given in scheduling the reviews as deemed appropriate for each individual child. The review must take place at least annually; however, the rapid growth and development of the preschool child will likely make it necessary to schedule reviews more often.

During any IEP review the team must readdress the appropriateness of the services and service delivery provided to the child, the least restrictive environment for the child, and any programming or planning for child-family goals or transition into other programs.

Specific areas in IEP development (annual goals, short-term objectives, family goals and objectives, and service delivery options) are described more fully in the following sections.

Annual Goals

Annual goals provide long-term statements of projected or expected child growth and an overall view in planning for all aspects of child development.

Guidelines for identifying annual goals include:

- The annual goals should be based on the assessment data and should acknowledge areas of strengths, weaknesses, learning styles, or learning modes unique to the child.
- The annual goals should include cognitive, psychomotor and affective domains of development as well as self-care skills in order to give attention to the total development of the child.
- The annual goals should reflect a multidisciplinary team effort, i.e., the goals should integrate all areas of development.

Short-term Instructional Objectives

Short-term instructional objectives are developed to provide a system for planning the child's instruction that is based on the annual goals. Short-term objectives are more detailed and are specific, measurable steps necessary to

bring a child from his current level of performance to the completion of annual goals. There are three components to the short-term objective: (1) a description of the specific behavior desired, (2) the conditions under which the behavior will be performed, and (3) criteria for acceptable performance. In some situations it will also be necessary to explain the specialized methods or materials required for an individual child.

Goals and Objectives for the Family

Family education and involvement may increase the success of the child's educational program and help parents cope with the responsibilities of educating and caring for the handicapped child. Including planning for family involvement as a part of the IEP process insures that child-family planning is not overlooked. The IEP should reflect family involvement in the goals and objectives developed for the child. See also pages 29 to 33 of this guide for more information on family involvement.

Service Delivery Options

Once a child's need for specially designed instruction is determined and goals and objectives are established to meet those needs, the IEP team must determine who will be responsible for implementation of the services based on stated goals and where the services will occur, always keeping in mind the least restrictive environment. The questions, "Who will be responsible?" and "Where will the services be provided?" are issues in service delivery that must be addressed in planning the most appropriate program for the individual child. The IEP team must consider a broad range of alternative services for the individual child before establishing which is the appropriate option for a given child's unique needs. Failure to consider a range of service delivery options may "short-circuit" planning for the child since options that may be more appropriate to the child's needs are not even considered. See the sections Provision for the Least Restrictive Environment on pages 17 to 18 and Service Delivery System on pages 19 to 28 of this guide.

Ongoing Monitoring

Although the IEP plans the annual goals and short-term objectives for the handicapped child, it is also necessary to develop a system for daily planning for the child's needs and documentation of efforts to meet those needs.

The daily plan should include:

Specific daily objectives and related instructional tasks that are expected to be completed by the child and are listed in behavioral terms.

Specific methods, materials, and strategies necessary to enhance the child's success in the completion of the tasks.

Criteria for successful completion of the tasks.

Documentation of the lesson, including child progress and comments regarding needed changes, anecdotal statements, relative mastery of tasks, relevant behaviors observed, etc.

The daily plans should reflect the annual goals and short-term objectives of the IEP. The daily recordkeeping system or documentation is a part of the IEP's evaluation and monitoring system that helps to ensure success of the child's program. The daily plan is a system for determining whether changes in the plan are warranted and whether the total plan is appropriate for the child.

Transition

The IEP team should consider any transitional arrangements that may be needed as a child's program placement changes. Planning should begin well in advance of the time of the transition to another program. If a child will be attending a regular classroom the following year, the goals of his/her current IEP should reflect skills necessary to insure success in the regular classroom setting, such as social skills. If a child is going to be placed in a self-contained special education classroom, the child's goals under his/her current IEP should also reflect development of skills necessary for success in the self-contained program. The IEP team may also outline other plans for the child's transition such as parent visitation to the new program, observations of the child in the program for preschool handicapped children by the receiving teacher, trial visits by the child to the new program, needed assessments, and so on.

In planning a child's IEP in preparation for services in the receiving program, the IEP team membership should include the teachers and staff from the current or sending program as well as teachers and staff from the receiving program. This eases the transition for both child and family and eliminates any unnecessary disruption in services. See also pages 132 to 140 in the Appendices for transition checklists for the program administrator, sending teacher, receiving teacher, and parents.

Evaluation of the IEP Process

Each IEP has its own evaluation and monitoring system built in as a component. The purpose of the evaluation and monitoring is to provide systematic feedback

to the program staff so they may make any necessary revisions or changes in the program.

In addition to being monitored for goals and objectives, the IEP and the planning process may also be evaluated as to appropriateness for the child and for adherence to regulations:

- Are the goals and objectives for the child appropriate?
- Are family goals and objectives included in the IEP and are they appropriate to the strengths and needs of the child-family situation?
- Are the implementers held accountable for programming?
- Are program changes being made based on reviews of the IEP, such as changes in strategies, methods, materials, resources, and eligibility of the child for other programs?
- Does the IEP reflect planning for transition for those children who are approaching the time for a program change?
- Are the IEPs being reviewed often enough?
- Is there a continuous monitoring procedure for each IEP, including daily progress notes or work samples or monitoring for other indicators of needed program changes that require an IEP review meeting?
- Was the timeline for planning and placement within the guidelines?
- Were the parents notified as to the time, location, and purpose of the meeting and who would be in attendance, and was this notification documented?
- Did the parents give written consent for placement?
- If the parents did not attend the IEP meeting, were the steps taken to involve parents well documented?
- Did the IEP team include the required members?
- Does the IEP document include the required components?

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Appendix A

Theoretical Models in Curricula and Assessment

Curricula, assessment procedures, and teaching methodology used in a program are based on theoretical models of education. Some theoretical models will ally themselves more closely to a program's philosophy than will others. Knowing those theoretical models that have had major impact on curriculum and assessment design in early childhood programs for handicapped children will assist programs in selecting or developing those appropriate to the needs of individual children and most consistent with program philosophy.

Four theoretical approaches form the basis for design of assessment and curricular materials for young handicapped children (Dunst, 1982). The first of these is the maturational or developmental model. Its foremost proponent was Arnold Gesell who viewed child development as genetically predetermined and ordered (Dunst, 1982). The assessments and curricula based on this model use developmental milestones assuming that development occurs in a predictable sequence and that this sequence is the appropriate teaching sequence (Bailey and Worley, 1984).

The second theoretical model is termed the interactionist perspective and is best known through Jean Piaget's cognitive-developmental model. As in the previous model, learning is viewed as sequential. In addition, learning is viewed as an interaction between the child and the environment. What is learned in each new experience must be integrated into prior learnings. Curricula and assessments based on the interactionist model are arranged heirarchically. The sequence corresponds to increasingly complex levels of problem solving (Dunst, 1982; Linder, 1983).

A third theoretical model is the environmental-learning model. It is better known as the behavioral approach and has been influenced by the work of B. F. Skinner. In this view, learning takes place when the environment is controlled (Dunst, 1982). Assessments and curricula are based on task analysis, breaking individual tasks into small, component steps. This analysis of tasks becomes largely the job of the professionals involved since few commercially available assessments and curricula have been developed for this model. Staff members must have specialized training to carry out this approach (Bailey and Worley, 1984).

The fourth model, which has affected development of curricula and assessments in early childhood education for handicapped children, is based on ecological theory. Its major proponent in the field of education for young handicapped children is Urie Bronfenbrenner. Learning is seen as a result of the child's interaction with the environment or ecology made up of settings, activities, and interpersonal relationships (Dunst, 1982). Assessment is based on a combination of procedures that assess the child, the family dynamics, the environment, and interpersonal interactions along with the interactions between these aspects of the ecology. Curricula must be developed by staff members or adapted from existing materials since none of the commercially available curricula account for this complex set of interrelated factors (see also Bronfenbrenner, U. The Ecology of Human Development. Cambridge, Mass.: Harvard University Press, 1979).

Appendix B

Classroom Organization

A classroom environment should support the behaviors and skills appropriate for the group of children enrolled. Before selecting or arranging the preschool classroom, consider the variables of the physical environment: (1) actual classroom space; (2) arrangement of activity areas within that space; (3) furniture and fixtures; (4) play and work material to be used; (5) activities of the program and their sequence; (5) number of staff; (6) number and type of children; and (7) grouping of staff and children.

The classroom should be arranged to increase the probability of children making desired responses while minimizing potentially disruptive elements. Once arranged, the classroom should be left so that consistency can be established for each student. A classroom for handicapped preschoolers should be organized to facilitate individual and small group instruction while eliminating as many visual and auditory distractions as possible through the use of fabric or carpet covered partitions.

At least six types of activity areas should be provided in the preschool classroom:

Quiet, calm activities: small group and individualized instruction, listening, viewing, meeting, and reading.

Structured materials or activities: puzzles, construction toys, blocks, manipulatives, group games, and instruction.

Craft and discovery activities: paint, clay, collage, pencils, crayons, blackboards, sand/water play, woodworking, science, plants, and animals.

Dramatic play activities: puppets, store, telephone, masks and dress-ups, kitchen and doll play.

Large motor activities (outdoor play area or adaptive physical education): climbing, sliding, crawling, running, hanging, tumbling, swinging, rocking, balls, large blocks, ring toss, nerf basketball, and scooters.

Therapeutic activities for sensory or physically disabled children. Sensory stimulation for severely handicapped preschoolers could include auditory, visual, tactile, kinesthetic or gustatory-olfactory stimulation that is activated by the child. Arrange a display such as mobiles,

- bright objects, twinkling Christmas lights or bells, and design an appropriate and safe connection between a selected motor movement of the child -- legs kick, head turns, or raised hand -- and the activation of the display.

Considerations in Organizing a Classroom

- Space should be arranged specifically for each activity: large groups vs. small groups or noisy activity vs. quiet activity.

- Tables, chairs, mats, and room dividers in individual and group work areas should be arranged to reduce the distractions of children and staff moving from one area to another.

- Separate noisy and quiet activities within the classroom, or schedule them at different times during the school day.

- Label materials and keep them adjacent to where they will be utilized. Diapers and extra sets of clothing should be stored close to the bathroom and diapering area.

- Individual carpet squares, rugs, or mats help minimize physical contact when instruction takes place on the floor.

- Wall or ceiling decorations should be utilized judiciously in areas where instruction occurs since they can be powerful distractors. They can provide added visual stimulation in areas where children are seated or positioned on the floor to look at the walls or ceiling. Play or diapering areas can be ideal places for wall or ceiling decorations.

- An area within the classroom away from the children's activities yet within earshot and sight can be utilized for parent or visitor observation. The daily activity schedule and written policies for classroom visitation should be posted in this area.

Environmental Considerations

Environmental arrangements within the classroom can support specific behaviors that are important when intervening with handicapped preschoolers. Ann Rogers-Warren (1982) provides ideas on how the environment can be utilized to encourage certain behaviors:

Promoting social interaction. Peers can be utilized as playmates and models of desired behaviors. Children with different skill levels can be paired by use of teacher prompts and praise, rearranging seating placements, establishing rules to bring a friend to an activity, or utilization of materials and games that require two or more players.

Facilitating Language and Communication. Materials can be arranged so that some desirable, attractive ones are visible, but not immediately accessible. Situations can then be created whereby models of appropriate verbalizations are provided or consistent nonverbal cues elicit verbalizations.

Utilizing small group instruction and consistent scheduling. Research has shown that small group instruction is more effective with some handicapped preschoolers than is one-to-one training. Scheduling should allow for both individual and small group work as is deemed appropriate for individual child needs. Scheduling that alternates between active and quiet activities and provides changes in setting allows for variations in children's attention spans. Overlapping scheduled activities so individual children move as they finish a task helps to eliminate group transitions that contribute to disruptive behavior. This type of staggered scheduling allows children with different attention spans continuous opportunities for participation.

Building independence. To build independence, children can be allowed accessibility to those items frequently needed. The bathroom facilities should be equipped with a stabilizing bar, a step stool, and a nonslip surface. The drinking fountain should be adapted for use by children in wheelchairs. Play materials can be kept on open shelves that are easily accessible. Children can be allowed to keep some materials such as pencils, crayons, or paper in their own cubby or tray. Opportunities can be provided for each child to pour juice, pass out napkins, choose a place to sit, or select a musical instrument. A consistent daily routine allows a child to anticipate the next activity and prepare for it independently.

Facilitating transition. Classroom arrangements should be gradually modified, especially during the latter part of the school year, to help the child learn new behaviors that will be expected of him or her in the next environment, whether it is a special class, kindergarten, or another program. If the child will be placed in a nonhandicapped setting, the classroom arrangement can be altered to utilize desks instead of tables and to include longer scheduled periods with fewer adults and less individual time. More specific rules can be formulated for speaking and work time.

Meeting the Special Needs of Handicapped Preschoolers

A checklist may provide useful feedback in evaluating classroom settings for preschool children with special needs.

How do things appear at the child's level? Are there interesting things to see and touch?

Is there room for a wheelchair-bound or awkwardly mobile child to negotiate in and out of spaces and turn around?

Are shelves and tables at a comfortable level for a child's height? Is there a place that can accommodate each child's handicap within each activity area (wheelchairs, walkers, bolsters, etc.)?

Are shelves, tables, sinks, and other fixtures sturdy enough to hold the weight of a minimally mobile child who may need support?

Are prosthetic devices easily accessible in areas where children might gain practice standing or sitting without an adult's assistance while engaged in an activity?

Are some of the materials and toys accessible to a child without assistance even if he or she is minimally mobile?

Is the sound level and acoustic arrangement of the room satisfactory for a child with a hearing impairment or a hearing aid? Are there some special quiet areas for children to work with minimal noise distraction?

Does the visual environment contain sufficient contrasts to attract the attention of a visually impaired child? Do color and light contrasts also indicate contrasts in texture and height?

Are the cues that designate different areas (use of color, change of level, dividers) clear and consistent?

How much of the environment is designed for self-management or self-engagement? How frequently do the children use these opportunities?

An excellent resource for designing a preschool classroom specific to serving children in wheelchairs, on crutches, in stryker frames, or in stretcher beds is Gordon, R. The Design of a Preschool "Learning Laboratory" in a Rehabilitation Center. New York: University of New York Medical Center, 1969. (ERIC Document Reproduction Service No. ED032096)

Curricula, Materials, and Equipment

Curricula

Curriculum refers to an organized description of what to teach, and should be selected or developed on the basis of a child's individual needs. Commercial, "in-house", and teacher-developed curricula can be used simultaneously to supplement and complement one another. Likewise, instructional activities from several curricula can be used to teach the same instructional skill.

The curriculum selected should be compatible with the program philosophy and theoretical approach to teaching. Skill areas that should be addressed within the scope of the total curriculum include cognitive, social, language, motor, and self-help skills. Mastery of the instructional skills should result in acceleration of a child's developmental progress and maximize independent functioning.

A curriculum evaluation checklist may be used to evaluate curricular materials being considered for adoption in the classroom. Two references for curriculum evaluation are:

- Linder, T. "Selecting and Using Curricula." Early Childhood Special Education: Program Development and Administration. Baltimore: Paul H. Brookes Publishing Co., 1983, pages 123-152.

- Worley, M. "Evaluating Curricula: Purposes and Strategies." Topics in Early Childhood Special Education. Vol. 2, No. 4, January, 1983, pages 15-24.

A curriculum may need to be modified so as to be appropriate for: (1) individualized instruction; (2) small group instruction; (3) meeting specific needs of the handicapped population to be served; (4) use by aides, parents, and other volunteers; (5) use with the data recording and monitoring system employed in the program; (6) integration of goals of other specialists (e.g. physical therapy).

Other practical criteria to consider in curriculum selection are listed below:

- Will preparation time prevent regular use?

- How often will it be necessary and how difficult will it be to replace consumable parts of the material?

- What is the price estimate?

- Are the technical aspects of the materials acceptable?
- Are storage and retrieval requirements difficult?

A review of eight preschool curricula with regard to the population targeted, adaptations for low-incidence handicapping conditions, theoretical perspective, assessment, validity, reliability, and evidence of effectiveness is published in Topics in Early Childhood Special Education, Vol. 2, No. 4, January, 1983, pages 51-66. The article by Fewell and Sandall is titled "Curricula Adaptations for Young Children: Visually Impaired, Hearing Impaired and Physically Impaired."

Materials

Materials should be selected to meet the needs of the child and should reflect the age, handicapping conditions, and characteristics of the child. Everyday items found in the home should be utilized whenever possible to facilitate generalization of skills from instructional setting to home.

Before purchasing materials, consider the following ideas:

- Content/Scope. Can the material be utilized in many ways to adapt to thevarying needs to the children?
- Prerequisite Skills. What skills, abilities, knowledge, or understanding must the child have in order to use the material successfully?
- Instructional/Interest Level. Is the interest level and level of difficulty appropriate for the children intended to use the material? Don't rely entirely on the publisher's or retailer's label.
- Sensory Modality. Is provision made for the learning style of the learner, whether it is auditory, visual, tactile, kinesthetic, or a combination of modes?
- Child Response. Is the response required appropriate to the child's abilities?
- Presentation of Information. Does the material motivate? Require participation? Reinforce the child with knowledge of results?
- Teacher Considerations. Is a teacher's guide provided? How much preparation time is involved?
- Cost/Value. What is the price (in terms of money and time invested) per unit of results?

In addition to these considerations, the U.S. Consumer Product Safety Commission's published guidelines on toy selection for children should also be adhered to in selecting materials for the classroom. Choose toys or materials that meet the following criteria:

- Too large to be swallowed.
- No detachable small parts that can be lodged in the windpipe, ears, or nostrils.
- Not apt to break easily into small pieces or leave jagged edges.
- No sharp edges or points.
- Not put together with straight pins, sharp wire, or nails that might easily be exposed.
- Not made of glass or brittle plastic.
- Labeled "non-toxic."
- No parts that can pinch fingers or catch hair.
- No cords or strings over 12 inches in length.
- Made of fabrics that are nonflammable, "flame retardant," or "flame resistant."
- "Washable" and "hygienic materials" notices attached to stuffed toys and dolls.
- No excessively loud noises.

A selected list of educational materials and companies that supply a variety of those materials commonly found in classrooms for preschool handicapped children is included in the Appendices. (Also see Landers, B. Early Childhood - Handicapped Resource Guide. Elkader, IA: Keystone Area Education Agency, 1980, pages 110-130. ERIC Document Reproduction Service No. ED 188 382).

Adaptive Equipment

Teachers of the preschool handicapped may require consultation to appropriately utilize adaptive equipment or adaptive methods. Local support personnel such as an occupational or physical therapist may provide that consultation or initiate a referral to an adaptive equipment specialist.

A physically or sensory involved preschool handicapped child may require adaptive equipment or adaptive methods to maximize independent functioning. A

selected list of adaptive equipment representative of the kinds of specialized materials that have been demonstrated useful in working with physically or sensory impaired preschool children is described in Appendix C on pages 86 to 97. References on the construction and design of adapted equipment and a selected list of commercial suppliers of adaptive equipment are also included in Appendix C.

APPENDIX C

Selected Preschool Handicapped Educational Materials and Toys

Language/Cognition and Readiness Center

preschool books/story books
magazines and catalogs
feely bag (box)
jumbo lotto game
pick - pairs game
memory card game
zoo animals (plastic or rubber)
farm animals (plastic or rubber)
fruits and vegetables (plastic)
flannel board
flannel board cutouts and stories
flannel board alphabet letters and numbers
pictures and objects for classifying
puzzle match-ups (animals and homes, colors and things, counting, go-togethers)
simple matching and lotto games (shape and color bingo, candyland)
magnetic board with letters and numerals
large wooden letters and numerals
colored 1-inch cubes
wooden cards
puppets
sequence cards
5 to 8 piece form board
puzzles (4-24 pieces) large knobbed puzzles
shapes sorting box
wooden shapes - variety of colors and sizes
picture cards (halves to whole, self-care sequential, same/different, spatial relations, association, actions, real objects
counters

Quiet Activities

nesting blocks
stacking toys
stringing beads (large wooden 1-inch, medium ½ inch, small ¼-inch) various colors and shapes
peg boards/pegs (large and small pegs)
lacing cards
shape and simple object templates
stacking rings
puzzles

Dramatic Play/Housekeeping Center

Fisher-Price radio
Fisher-Price family house, school, garage, hospital, farm or airport
Fisher-Price record player
Fisher-Price medical kit
Fisher-Price bus
housecleaning set - broom, mop, dustpan
play dishes, pots, pans, silverware
dolls
doll baby bottle
child size kitchen set - stove, refrigerator, sink, cupboard, (wood is most durable)
small play suitcase
play table and chairs
toy telephones
puppets
doll crib or buggy
jack-in-the-box
child height, full-length unbreakable mirror
dress-up clothes/purses/hats
pull toys
doll house
pop beads
See-N'-Say
child's rocking chair
clothes rack
representations of food
toy cash register

Block Center

Bristle blocks
wooden blocks
large stacking blocks
Tinker Toys (regular or giant)
Lego blocks
vehicles - cars, trucks, tractors, boats, airplanes (large/wood/small wood/plastic)
plastic or rubber farm or zoo animals
train set (wooden or plastic)

Block Center cont.

- plastic, rubber or wooden people representing various family members and community helpers
- wooden traffic signs
- Duplo blocks

Sand - Water Table

- pails
- small shovels or rakes
- molds of various objects or shapes
- sand sieve
- containers of various sizes
- funnels
- toy boats

Gross Motor Equipment

- teeter boats
- riding toys or trikes (regular or adapted)
- scooters
- wagons
- balance beam
- acitivity hoops
- balls - nerf, soccer, rubber, softballs, beachballs (large, madium and small sized)
- bean bags
- tumbling mat
- tunnel
- equilibrium boards (large and small)
- jungle gym w/slide and ladder
- parachute

Art Supplies

Paper

- butcher paper
- fingerpaint paper
- construction paper
- manila drawing paper
- tissue paper
- easel paper
- waxed paper

Paint

- fingerpaint
- tempera
- watercolors

Paint Brushes

- large primary watercolor brushes

Painting Easel

- adjustable heights

Scissors

- child-sized right & left
- double handled
- easy grip or loop

Paint Smocks

- old shirts
- large garbage bags, with holes cut for head and arms

- nonspill paint holders
- sponges
- pencil grips
- crayons
- yarn
- modeling clay
- drying rack (for painting pictures)
- adaptive pencil holders
- colored chalk
- pipe cleaners
- liquid laundry starch
- food coloring
- foil
- glue
- string
- felt
- white flour
- clothespins
- pencils
- paste
- glitter
- Playdoh
- wheat powder

Sensory Motors

- mobiles
- busy box
- soft toys
- small flashlight
- paper for crumpling
- musical instruments
- various textures of cloth/paper products
- rattles/shakers
- early development toys
- rag doll
- small twinkling Christmas tree lights
- bright colored teething rings
- shaving cream

Cooking Equipment

- cookie cutters
- funnels
- small plastic bowls, empty margarine containers
- plastic cups (for milk, juice)
- can opener
- spoons - (mixing and small)
- small pitchers or handled measuring cups for pouring
- measuring spoons
- egg beaters
- cake pans

Sensory Motors cont.

- hand lotion
- incline boards
- large balls
- cereals or noodles in a tub
- mats
- pillows

Cooking Equipment cont.

- cookie sheets
- hot pads
- paper plates
- rubber spatula
- egg timer
- popcorn popper

Music/Library/Audiovisual Equipment

- rhythm instruments
- cassette tape recorder
- blank cassette tapes
- cassette story books
- feely books
- scratch N' sniff books
- record player
- earphones for record player or cassette recorder
- preschool books/storybooks picture books
- records or cassettes, rhythm activities, creative movement, nursery songs and rhymes

Science

- magnifying glass
- live plants
- live pets (if allowed depending on school or health policies)
- prism
- large and small magnets

access to: movie screen, film projector, slide projector, movie projector, closed-circuit television

Learning Kits - Games

Kits are a major expense to the preschool handicapped classroom budget. Decisions on whether to purchase kits should consider priorities for material acquisition budget limitations, and the needs of the children.

Peabody Early Experiencers Kit

American Guidance: A self-contained kit of lessons and materials to promote the cognitive, effective, and oral language development of prekindergarten children (mental age - advanced 2 year olds, average 3 year olds, and less mature 4 year olds)

GOAL: Mathematical Concepts Kit (Milton Bradley)

Sequential, developmental series of lessons designed to offer opportunities for initial mathematical discoveries.

GOAL: Level 1, Language Development.

Sequential lesson plans designed to help children acquire the language skills basic to learning to read. The program is divided into eleven language processing skill areas: auditory and visual reception, auditory and visual association, verbal and manual expression, auditory and visual memory, and grammatic, auditory, and visual closure. Published by Milton Bradley.

Dubnoff School Program 1.

A sequential pre-writing program with three progressive levels. Level 1 includes horizontal, vertical, circular, diagonal, and intersecting lines; and geometric shapes. Level 2 incorporates combinations of strokes and strokes with directional changes. Level 3 contains strokes for upper - and lower-case letters and numerals in addition to manuscript writing. Available from Teaching Resources.

All-Purpose Photo Library

A set of full-color life-like pictures which are available in two sets subdivided into 28 categories. The categories include such areas as animals, food, toys, transportation, community workers, senses, household items, and so forth. These pictures are valuable for teaching oral communication skills and are available from DLM Teaching Resources.

General Furniture

- chalkboards and bulletin boards positioned at the child's eye level
- storage cabinets
- wastebaskets, covered garbage can for food disposal, separate lined basket for disposal of diapers
- partitions/room dividers
- adjustable height tables
- kidney (shape) table
- cubbies for childrens' belongings
- coat and book rack or individual locker at the child's reaching level
- low shelves within childrens' reach
- teacher desk and chair
- desk file cabinet

Supplies

teacher:

consumable

- rubber bands
- staples
- push pins
- clear contact paper
- paper clips
- paper - copy, letterhead plain bond, tagboard
- stickers
- calendar
- string
- tape - masking, transparent, strapping
- pens and pencils
- markers
- thumb tacks
- poster board

nonconsumable

- stop watch
- 3-hole paper punch
- clipboards
- bulletin board pictures
- stapler
- scissors
- yard stick

Access to: duplicating machine, copy machine, opaque projector, overhead projector, typewriter

children:

consumable

- chalk
- paper towels
- toilet tissue
- soap
- Kleenex tissues
- pencils
- paste
- paint - finger, tempera, water colors
- disposable diapers (supplied by parents)
- paper - newsprint, primary lined, finger paint paper, easel paper, construction paper, butcher paper
- crayons
- glue
- art supplies

nonconsumable

- chalkboard erasers
- potty chair
- washcloths
- pencil sharpener
- bibs
- carpet squares to sit on floor for group activities

Health First Aid Equipment

tweezers	cotton balls
first aid kit	book on administering first aid
thermometer	vaseline
disinfectant	blanket
comb/brush (for each child)	toothbrushes and toothpaste

Suppliers of Preschool Teaching Materials

Following is a selected list of companies which offer a good selection of teaching materials applicable to preschool handicapped children.

ABC School Supply
437 Armour Circle, NE
Atlanta, GA 30324

American Guidance Service
Publishers Building
Circle Pines, MN 55014

Childcraft Educational Corp.
20 Kilmer Road
Edison, NJ 08817

Colborne School Supply
Box 1398
Grand Forks, ND 58206

Constructive Playthings
1040 East 85th Street
Kansas City, MO 64131

DLM
7440 Natchez Avenue
Niles, IL 60648

Edmark Associates, Inc.
13241 Northrup Way
Bellevue, WA 98005

Kaplan School Supply Corp.
600 Jamestown Road
Winston-Salem, NC 27103

Latta School Supply
2218 Main Street
Cedar Falls, IA 50613

Northern School Supply
PO Box 2627
Fargo, ND 58102

J.A. Preston Corp.
71 Fifth Avenue
New York, NY 10003

Rifton Equipment for the Handicapped
Route 213
Rifton, NY 12471
(This company is also the source for Community Playthings, a catalog for non-handicapped children)

Adaptive Equipment

The following selected list of adaptive equipment is representative of the kinds of specialized materials which may be required to meet the unique needs of a handicapped preschool child.

Balance:

Air flow mats - Portable air filled mats used for relaxation and stimulation. Available from Skill Development Equipment Company (SDE).

Balls - Used for relaxation, stimulation, improving equilibrium reactions, and weight bearing. The Swiss gymnastic ball is excellent for practicing equilibrium reactions and improving sitting balance and weight bearing. Balls of varying sizes can be used, 17 inch, 21 inch, 26 inch, 30 inch or 42 inch. Available from Preston or SDE.

Mats - A dense, sturdy mat is essential for working with a child on the floor. Mats may be hinged in the middle for ease of portability and storage or inclined. Available from most manufacturers.

Adaptive Equipment cont.

Benches - Wooden benches of varying sizes can be used for practicing sitting balance or improving kneeling. The bench should be the appropriate size for the child when the child is sitting, the feet should firmly touch the floor. The bench should be of the correct width if the child is straddle sitting. Benches can be easily made or purchased locally.

Inflatables - Plastic blow up inflatables in various sizes promote equilibrium reactions and gentle vestibular stimulation while the child rolls on it. Available from Preston and Sammons.

Net swings/hammocks - Can be suspended from the ceiling and lined with soft pillows or bean bags. Provides good vestibular stimulation and relaxation for tight or excitable students. Available from a local sporting goods store.

Vestibular board - A rocking platform which stimulates equilibrium responses while providing controlled vestibular input. Can be large enough for a child to lie on or small enough to improve sitting, kneeling, and standing balance. Can be made out of wood and covered with carpet or can be ordered from several manufacturers.

Locomotion:

Adaptive tricycles - May be hand driven or equipped with separate trunk supports or special pedals to enable physically handicapped children to use a trike independently. Foot pedals are also useful for young children who push the trike with their feet rather than pedal it. Available from Preston.

Crawl trainer - A "T" shaped scooter with wheels which facilitates crawling by placing the child face down with the arms above the legs below the cross bar. Available from Preston.

Scooter boards - Available in a variety of sizes from small squares to long, full body ones for very physically involved students. The long full body ones can often be used as a means of mobility as well as providing a therapeutic position. Scooter boards can be constructed with universal casters and a piece of carpet attached to the top of a board or purchased from Sammons or Preston.

Positioning:

Beanbag chairs - Inexpensive method of providing comfortable seating for some physically handicapped children. Can be modified through use of pillows or sandbags.

Blocks or telephone books - Quick and inexpensive method of modifying a chair. A child should sit in a chair with feet flat on the floor and hips placed firmly against the back of the chair. Blocks or telephone books placed under the child's feet or behind the child's back can facilitate this position.

Bolsters - Can be used to position a child prone, facilitate weight bearing on the hands or equilibrium reactions, and practice sitting balance or straddle sitting. Can be homemade from sono tubes (forms for concrete construction) covered with foam and then vinyl. Also, available commercially. Community Playthings supplies bolsters whose height from the floor can be adjusted. Soft foam filled bolsters are available from SDE.

Adaptive Equipment cont.

Cut Out tables - Adjustable tables which allow children, particularly those in wheelchairs to sit close to the work area. Available with one or more cut outs.

Educubes - Versatile plastic cubes which can be used as desks, surfaces to play on while practicing kneeling, or chairs. They can be used upright or turned upside down so that the seat is closer to the floor for smaller children. Available from Beckley Cardy Company.

Inner tubes - Small inner tubes can provide good support for children with poor sitting balance who can sit in the middle of the tube.

Prone standers - Allows upright positioning for some physically involved children which improves visual attention and head and trunk control and enhances fine motor ability. Child can be positiioned at various angles and at different surfaces for working. Available from several manufacturers or can be constructed.

Sandbags or pillows - Used for positioning physically involved children. Available in a variety of sizes and shapes to suit different purposes. Can be purchased commercially or constructed.

Side lyers - A long piece of wood attached to a wooden base with 2 or 3 straps or pads attached to it. A child can be placed with his or her back against the side lyer with straps or pads across the chest. The child's hands are then left free for fine motor activities. Available from Community Playthings.

Specialized seating devices - Usually recommended and/or constructed by a physical or occupational therapist to suit the individual child. Wooden relaxation chairs are available from most manufacturers. Community Playthings supplies well made adapted chairs in various sizes, including a corner floor sitter. Adjustable corner and bolster chairs are also available from L. Mulholland Corporation.

Standing tables - Wooden box like tables allow a child who cannot stand independently to stand supported and do table work. Available for 1, 2, or 4 children and can be purchased adjustable for children of different heights. A standing table is bulky and can take up considerable room. Available from L. Mulholland Corporation.

Tilt top school desks - Allows movement of a work surface off the horizontal slightly and into a vertical plane. Preston supplies adjustable tilt-top desks. Adaptations to achieve this position can also be made with the use of an easel or a drafting table with a catch ledge.

Wedges - A firm foam wedge covered by naugahyde or vinyl facilitates a prone-on-elbows position which can improve visual skills as well as head and trunk control. Wedges can be used for positioning, particularly to help drain the lungs of excess mucus which is important to children who cannot move around or change positions on their own. Wedges provide good positions for more functional hand use. Available in a variety of sizes from several manufacturers.

Adaptive Equipment cont.

Adaptive feeding aids - These aids promote independent eating skills with motorically involved children and are availalbe from Sammons as well as other manufacturers. Some of the feeding aids commonly used include:

scoop dishes	quad-quip untensil holders	swivel spoons
suction cups	covered straw cups	cut out plastic cups

dycem: A nonslip plastic which can be used under plates or bowls to help hold them during eating.

References on Design, Construction and adaption of Equipment

The following sources (Cadez, 1984; Gendreau, 1980) provide information regarding the design, construction and adaptation of equipment appropriate to use by physically handicapped preschool children.

Developmental Physical Management for the Multi-Disabled Child
Beverly Buttram, OTR and Glenna Brown, M.A.
Order from:
Dr. Lorete Holder
The University of Alabama
Area of Special Education
P.O. Box 2592
University, AL 35486

Feeding the Handicapped Child
Mary Ann Harvey Smith, Ed.
Child Development Center
Department of Nutrition
711 Jefferson Avenue
Memphis, TN 38105

Functional Aides for the Multiply-Handicapped
Isabel P. Robinault
Order from:
Harper and Row, Publishers
10 East 53rd Street
New York, NY 10022

Handling the Young Cerebral Palsied Child at Home
Nancie R. Finnie
Order from:
E.P. Dutton and Co., Inc.
2 Park Avenue
New York, NY 10003

Homemade Battery Operated Toys and Educational Devices for Severely Handicapped Children
Linda Burkhart
R.D. 1, Box 124
Millville, PA 17846
or
8315 Potomac Avenue
College Park, MD 20740

How to Build Special Furniture and Equipment for Handicapped Children
Ruth B. Hoffman, OTR
Order from:
Charles C. Thomas, Publisher
301-327 East Lawrence Avenue
Springfield, IL 62703

Managing Physical Handicaps
Beverely Fraser, R.P.T., and Robert N. Hensinger, M.D.
Order from:
Paul H. Brookes Public Company
PO Box 10624
Baltimore, MD 21204

Program Guide for Infants and Toddlers with Neuromotor and Other Developmental Disabilities
Frances P. Connor, G. Gordon Williamson, and John M. Siepp
Order from:
Teachers College Press Columbia University
1234 Amsterdam Avenue
New York, NY 10027

Selected Equipment for Pediatric Rehabilitation
Compiled by Ardrienne Bergen, RPT
Order from:
Blythedale Children's Hospital
Broadhurst Avenue
Valhalla, NY 10595

Therapeutic Positioning Equipment for the Multiply-Handicapped - A Neurodevelopmental Approach to its Design and Development
Maryana B. Baez, LPT
Order from:
Paul Adamovich, COTA
42 Elmwood Road
Frankfort, NY 13340

Treatment of Cerebral Palsy and Motor Delay
Sophie Levitt
Order from:
J.B. Lippincott Co., Publishers
Rittenhouse Square
Philadelphia, PA 19107

Commercial Suppliers of Adaptive Equipment

The following represents a selected list of companies (Cadez, 1984; Genreau, 1980) who manufacture or supply adaptive equipment applicable for handicapped preschool children.

Abbey Medical
44 East 600 South
Salt Lake City, UT 84115
Medical equipment, adaptive devices, and equipment for the handicapped.

Commercial Suppliers of Adaptive Equipment cont.

Achievement Products, Inc.
PO Box 547
Mineola, NY 11501
Carries wedges, bolsters, mirrors, strollers, etc.

Adaptive Therapeutic Systems, Inc.
883 Boston Post Road
Madison, CT 06443
Manufactures prone boards, self-feeding systems, lap boards, safety harnesses, wheelchairs, etc.

Beckly-Cardy Co.
1900 North Narragansett
Chicago, IL 60639
(312) 622-5420
Carries mostly educational supplies but their educubes and speech mirror are among some of their therapeutic equipment.

Be OK Self-Help Aids
Fred Sammons, Inc.
Box 32
Brookfield, IL 60513
(800) 323-7305
Another large and popular company that deals particularly with self-help aids.

Childsafe
PO Box 633
Pacific Palisades, CA 90272
Bath supports, Ridem Chair.

Community Playthings
Rifton, NY 12471
Has particularly well-made adapted chairs, bolsters, wedges, prone boards and adapted tricycles as well as typical play equipment.

Everest and Jennings, Inc.
1803 Pontius Avenue
Los Angeles, CA 90025
One of the largest manufacturers of wheelchairs.

Fredrickson Orthopedic's, Inc.

723 North Pacific Avenue	1911 North 11th Street
Fargo, ND 58102	Bismarck, ND 58501
(701) 237-4455	(701) 258-4745

Supply Everest and Jennings wheelchairs, measure children for wheelchairs and adapt wheelchairs; supply adaptive feeding equipment, braces, canes and crutches.

Commercial Suppliers of Adaptive Equipment cont.

Kaye Products, Inc.
202 South Elm Street
Durham, NC 27701
(919) 688-1601
Prone standers, corner chairs, bolster chairs, adapted strollers, seat inserts; chairs are well-made and reasonably priced.

MED (Medical Equipment Distributors)
1701 First Street
Maywood, IL 60153
(312) 681-2828
This is the main office for this distributor of wheelchairs and other equipment for special children. They have approximately 35 distributors in the United States.

L. Mulholland Corporation
215 North 12th Street
Santa Paula, CA 93060
Adaptive chairs, prone standers, supine standers, standing tables, and good adaptable wheelchairs.

Prentke Romich
R.D. 2, Box 191
Shreve, OH 44676
Electronic communication devices.

J.A. Preston Corporation
71 Fifth Avenue
New York, NY 10003
A very large company that has virtually every type of equipment. Areas of equipment listed in a recent catalog include:
assessment and training materials
cognitive skills
self-help aids and social perception (including some feeding equipment)
perceptual motor activities
sensory perception
neuromuscular development
therapeutic recreation
furniture and equipment for handicapped children

Self-Start Manufacturing Company
187 O'Brien Highway
PO Box 232
Cambridge, MA 02141
This company manufactures clothing that is especially tailored for children and adults with disabilities. The garments look like those purchased in any store but are made so that they can be put on and taken off with a minimum of effort.

Commercial Suppliers of Adaptive Equipment cont.

Skill Development Equipment Company (SDE)
Box 6300
1340 North Jefferson
Anaheim, CA 92807
(714) 524-8750
A favorite among therapists and teachers for well-made, sturdy bolsters, wedges, and large balls.

Telesensory Systems
3408 Hillview Avenue
PO Box 10099
Palo Alto, CA 94304
Communication devices.

APPENDIX D

Basic Assessment Tools

ASSESSMENT IN INFANCY. ORDINAL SCALES OF PSYCHOLOGICAL DEVELOPMENT

Author: I. Uzgiris and J.M. Hunt
Publisher: University of Illinois Press
Chicago, Illinois

Age Range: 2 Weeks - 2 Years

Areas Covered: Cognitive - Piagetian sensorimotor stage

Scoring: Level of cognitive organization

Other: Intervention programs can be designed from the results of this assessment

BOEHM TEST OF BASIC CONCEPTS

Author: A.E. Boehm

Publisher: The Psychological Corporation
304 East 45th Street
New York, NY 10017

Age Range: 4 - 8 Years

Areas Covered: Basic concepts of time, quantity, and space

Scoring: Percent correct

Other: A resource guide is also available

BRIGANCE DIAGNOSTIC INVENTORY EARLY DEVELOPMENT

Author: A.H. Brigance

Publisher: Curriculum Associates, Inc.
5 Esquire Road
North Villerica, Massachusetts 01862

Age Range: 0 - 7

Areas Covered: Psychomotor, self-help, communication, general knowledge and comprehension, and academic skills

Scoring: Developmental ages

Other: Results are easily translateble into sequential, individualized activities

COMPREHENSIVE DEVELOPMENTAL EVALUATION CHART

Author:

Publisher: El Paso Rehabilitation Center
2630 Richmond
El Paso, TX 79930

Age Range: 0 - 3 Years

Areas Covered: Global Assessment Scale

Other: Use for profoundly handicapped children

DEVELOPMENTAL POTENTIAL OF PRESCHOOL CHILDREN

Author: E. Haeussermen

Publisher: Grune & Stratton, Inc.
381 Park Avenue South
New York, NY 10016

Age Range: 2 - 8 Years

Other: Developed for use with mentally retarded, orthopedically impaired, speech impaired, visually or hearing impaired, emotionally disturbed

THE DEVELOPMENTAL PROFILE

Authors: Gerald Alpern, Thomas Boll

Publisher: Psychological Development Publications
P.O. Box 3198
Aspen, CO 81611

Age Range: 0 - 12 Years

Areas Covered: Inventory of developmental skills

Scoring: Developmental ages

Other: Useful as interview instrument with parents, teachers, etc.

ERHARDT DEVELOPMENTAL PREHENSION ASSESSMENT

Author: Rhoda Erhardt (in Developmental Hand Dysfunction)

Publisher: RAMSCO Publishing
PO Box N
Laurel, MD 20707

Age Range: 0 - 15 Months (Developmental ages for hand development)

Other: Prehension development and evaluation of prewriting and writing skills. Checklist used for all handicapping conditions where fine motor impairment is suspected.

HAWAII EARLY LEARNING PROFILE (HELP)

Authors: S. Furuno, K. O'Reilly, C. Hosaka, T. Inatsuka, T. Allman, B. Zeisloft

Publisher: Vort Corporation
P.O. Box 11132
Palo Alto, CA 94306

Age Range: 0 - 3 Years

Areas Covered: Gross motor, fine motor, conceptual, language, social, self-help

Scoring: Items age graded by month, chart format

Other: Indexed Guide to 2,000 prescriptive activities also available

HISKEY-NEBRASKA TEST OF LEARNING APTITUDE (for deaf children)

Author: M.S. Hiskey

Publisher: Union College Press
Lincoln, NE

Age Range: 3 Years to 17 Years

Areas Covered: Cognitive

Scoring: Learning age and learning quotient for deaf children; mental age and deviation IQ score for hearing children

LEARNING ACCOMPLISHMENT PROFILE (LAP)

Author: A.R. Sanford

Publisher: Kaplan School Supply
600 Jamestown Road
Winston-Salem, NC 27103

Age Range: 1 Month to 6 Years

Areas Covered: Gross motor, fine motor, receptive and expressive language, cognitive, self-help, personal-social

Scoring: Summary score for each area, developmental profile, rate of development

Other: The LAP is cross referenced to instructional objectives in the Planning Guide for Preschool Curriculum

LEITER INTERNATIONAL PERFORMANCE SCALE

Author: R.G. Leiter

Publisher: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025

Age Range: 2 Years to Adult

Areas Covered: Nonverbal general intelligence test

Scoring: Overall IQ score

McCARTHY SCALES OF CHILDREN'S ABILITIES

Author: D. McCarthy

Publisher: The Psychological Corporation
304 East 45th Street
New York, NY 10017

Age Range: 2 Years, 6 Months to 8 Years, 6 Months

Areas Covered: Verbal, perceptual performance, quantitative, general cognitive, memory, and motor

Scoring: Scale scores and a general cognitive index score

MERRILL-PALMER LANGUAGE SCALE

Publisher: C.H. Stoltting & Co.
Chicago, IL

Age Range: 1 Year, 6 Months to 7 Years

Areas Covered: Receptive and expressive language abilities and articulation

Scoring: Age equivalent scores

MOVEMENT ASSESSMENT OF INFANTS

Author:

Publisher: Department of Physical Therapy
University of Washington
Seattle, WA

Age Range: 0 - 1 Year

Areas Covered: Motor Development

Scoring: Systematic appraisal of early motor behavior

OREGON PROJECT FOR VISUALLY IMPAIRED AND BLIND PRESCHOOL CHILDREN SKILLS INVENTORY

Authors: D. Brown, V. Simmons, J. Methoin

Publisher: Jackson County Education Service District
101 North Grape Street
Medford, OR 97501

Age Range: 0 - 6 Years

Areas Covered: Cognition, language, self-help, socialization, fine motor, and gross motor

Scoring: Skills inventory checklist, or conversion to standard scores is possible

Other: Curriculum and prescriptive programming components are also available

PEABODY DEVELOPMENTAL MOTOR SCALES

Authors: R. Folio & R. DuBose

Publisher: IMRD Publications
Box 154
George Peabody College
Nashville, TN 37203

Age Range: 0 - 7 Years

Areas Covered: Gross motor, fine motor

Scoring: Summary scores, developmental age

PEABODY PICTURE VOCABULARY TEST

Author: Lloyd M. Dunn

Publisher: American Guidance Service
Publisher's Building
Circle Pines, MN 55014

Age Range: 2½ Years to 18 Years

Areas Covered: Receptive vocabulary

Scoring: Mental age

Other: Requires pointing response to named pictures

PLAY ASSESSMENT SCALE 3RD REVISION

Author: Rebecca Fewell

Publisher: University of Washington
Seattle, WA 98195

Age Range:

Areas Covered: Play behavior

Scoring: Checklist

PORTAGE GUIDE TO EARLY EDUCATION CHECKLIST, REVISED

Authors: S. Blums, M. Shearer, A. Frohman, J. Hilliard

Publisher: The Portage Project
Cooperative Educational Service Agency 12
412 East Slifer Street
Portage, WI 53901

Age Range: 0 - 6 Years

Areas Covered: Infant stimulation, socialization, language, self-help, cognitive and motor

Scoring: Checklist of skills present

Other: Activity cards included for use in skill development

THE SEQUENCED INVENTORY OF COMMUNICATION DEVELOPMENT (SICD)

Author: D. Hedrick et al

Publisher: University of Washington Press
Seattle, WA

Age Range: 4 Months to 4 Years

Areas Covered: Receptive and expressive language development

Scores: Age equivalents

Other: Incorporates specific parental report and clinical observation

STANFORD-BINET INTELLIGENCE SCALE, FORM L-M

Authors: Lewis M. Termand, Maud A. Merrill

Publisher: Houghton-Mifflin Co.
Boston, MA

Age Range: 2 -18 Years

Areas Covered: General Intellectual Ability

Scoring: Intelligence Quotient

Other: Appears to have a large concentration of verbal items

TEST FOR AUDITORY COMPREHENSION OF LANGUAGE (TCL)

Author: E. Carrow

Publisher: Learning Concepts
2501 N. Lamar
Austin, TX 78705

Age Range: 0 - 3 Years and 6 - 11 Years

Areas Covered: Language

Scoring: Only nonverbal pointing responses are required

Other: Test is also available in Spanish

WECHSLER PRESCHOOL AND PRIMARY SCALE OF INTELLIGENCE (WPPSI)

Author: D. Wechsler

Publisher: The Psychological Corporation
304 East 45th Street
New York, NY 10017

Age Range: 4 Years to 6 Years, 6 Months

Areas Covered: Cognitive

Scoring: Separate verbal and performance IQs, full scale IQ

APPENDIX E

Screening Instruments

BIRTH TO THREE DEVELOPMENTAL SCALE

Author: T.E. Bangs & S. Dodson
Publisher: Teaching Resources
100 Boylston
Boston, Massachusetts 62116

Age Range: 0-3 Years

Areas Covered: Gross motor, fine motor, receptive and expressive language, cognitive, personal-social
Scoring: Summary score for each content area, developmental age, developmental profile

COMPREHENSIVE IDENTIFICATION PROCESS

Author: R. Reid Zehrbach
Publisher: Scholastic Testing Service
480 Meyer Road
Bensenville, Illinois 60106

Age Range: 3-5 Years

Areas Covered: Cognitive/verbal, fine motor, gross motor, speech and expressive language, social/affective, hearing and vision
Scoring: Pass, evaluate, refer, rescreen

DELRIO LANGUAGE SCREENING TEST

Author: A. Toronto, D. Leverman
Publisher: National Educational Publishers, Inc.
P.O. Box 1003
Austin, Texas 78767

Age Range: 3-7 Years

Areas Covered: Receptive Language
Scoring: Subtest totals
Other: Spanish and English

DENVER DEVELOPMENTAL SCREENING TEST (DDST)

Author: W.K. Frankenburg & J.B. Dodds
Publisher: Lodoca Project & Publishing Foundation
East 51st Avenue & Lincoln Street
Denver, Colorado 80216

Age Range: 1 Month to 6 Years

Areas Covered: Personal-social, fine motor-adaptive, language and gross motor development
Scoring: Developmental levels. Items scored as passed, failed, refused or no opportunity

DEVELOPMENTAL ACTIVITIES SCREENING INVENTORY II (DASI-II)

Author: Rebecca Fewell & Mary Beth Langley
Publisher: PRO-ED
5341 Industrial Oaks Boulevard
Austin, Texas 78735

Age Range: 0-5 Years

Areas Covered: Cognitive, fine motor
Scoring: Summary area scores, developmental age
Other: Can be adapted for use with visually impaired and has been used successfully with multiply handicapped children

DEVELOPMENTAL INDICATORS FOR THE ASSESSMENT OF LEARNING (DIAL)

Author: C. Mardell & D. Goldenberg
Publisher: Childcraft Education Corporation
20 Kilmer Road
Edison, New Jersey 08817

Age Range: 2 Years 6 Months to 5 Years 6 Months

Areas Covered: Gross motor, fine motor, concepts, communication and social-emotional level

DEVELOPMENTAL PROFILE

Author: G.D. Alpern & T.J. Boll
Publisher: Psychological Development Publications
7150 Lakeside Drive
Indianapolis, Indiana 46278

Age Range: 6 Months to 12 Years

Areas Covered: Gross motor, fine motor, receptive and expressive language, cognitive, self-help, personal-social
Scoring: Summary score for each content area, overall IQ, developmental age, developmental level
Other: Individually rated from direct observation or parent interview

DEVELOPMENTAL SCREENING INVENTORY

Author: H. Knobloch, B. Pasamanick & E.S. Sherard
Available From: Division of Child Development
Department of Pediatrics
Ohio State University College of Medicine
Columbus, Ohio 432??

Age Range: 1-18 Months

Areas Covered: Gross motor, fine motor, receptive and expressive language, cognitive, self-help, personal-social
Scoring: Summary score for each area, developmental age

ELIOT-PEARSON SCREENING PROFILE

Author: Samuel J. Meisels
Available From: Eliot-Pearson Department of Child Study
Tufts University
Medford, Massachusetts 02155

Age Range: 4 Years 6 Months to 5 Years 6 Months

Areas Covered: Perceptual, motor and language

HOME OBSERVATION FOR MEASUREMENT OF THE ENVIRONMENT (HOME)

Author: B. Caldwell and R. Bradley
Publisher: Center of Child Development and Education
University of Arkansas at Little Rock
33rd & University
Little Rock, Arkansas 72204

Age Range: 0-3 Years, 3-6 Years

Areas Covered: Frequency and stability of adult contact, amount of development and stimulation, need gratification, emotional climate, avoidance of restriction on motor and exploratory behavior, types of play materials available
Scoring: Verbal report of parents and direct observation

INFANT TEMPERAMENT QUESTIONNAIRE TODDLER TEMPERAMENT QUESTIONNAIRE

Author: W. Carey & S. McDevitt Author: Dr. Fullard
Available From: Department of Educational Psychology
Temple University
Philadelphia, Pennsylvania 19122

Age Range: 4-8 Months, 1-3 Years

Areas Covered: Nine temperamental characteristics
Scoring: Easy, difficult, slow to warm up categories

MANUAL OF DEVELOPMENTAL DIAGNOSIS: THE ADMINISTRATION OF THE REVISED GESELL AND AMATRUDA DEVELOPMENTAL AND NEUROLOGIC EXAMINATION

Author: Hilda Knobloch, B. Pasamanick, et al
Publisher: Harper and Row
Hagarstown, Maryland 21740

Age Range: 4 Months to 72 Months

Areas Covered: Adaptive (cognitive, perceptual problem solving), gross motor, fine motor, language and personal-social
Scoring: Estimates of developmental maturity

MAXFIELD-BUCHOLZ SCALE OF SOCIAL MATURITY

Author: K. Maxfield & S. Bucholz
Available From: American Foundation for the Blind
15 West 15th Street
New York, New York 10011

Age Range: 0-5 Years

Areas Covered: Self-help, personal-social
Scoring: Overall summary score
Other: Is for visually impaired children, an adaptation of the Vineland

MILANI-COMPARETTI MOTOR DEVELOPMENT SCREENING TEST

Author: Revision by Meyer Children's Rehabilitation Institute
Available From: Meyer Children's Rehabilitation Institute
University of Nebraska Medical Center
Omaha, Nebraska 69131

Age Range: 0-2 Years

Areas Covered: Gross motor
Scoring: Summary score, developmental profile
Other: Administered by a physician, therapist or nurse

MILLER ASSESSMENT FOR PRESCHOOLERS

Author: Miller
Available From: KID Foundation for Knowledge in Development
1901 West Littleton Boulevard
Littletown, Colorado 80120

Age Range: 2 Years 6 Months to 5 Years 6 Months

Areas Covered: Sensory, motor, cognitive and combined complex abilities
Scoring: Individual item scores, percentile ranks

MINNESOTA CHILD DEVELOPMENT INVENTORY

Author: H. Ireton & E. Thwing
Publisher: Behavior Science System
5701 Hawkes Terrace
Minneapolis, Minnesota 55436

Age Range: 1-6 Years

Areas Covered: Gross motor, fine motor, receptive and expressive language, self-help, personal-social, situation comprehension
Scoring: All report items, summary score for each content area, developmental profile
Other: Parent fills out questionnaire

NORTHWESTERN SYNTAX SCREENING TEST

Author: L. Lee
Available From: Dr. Laura Lee
Northwestern University
Evanston, Illinois 60201

Age Range: 1-6 Years, 6-10 Years

Areas Covered: Receptive and expressive language
Scoring: Percentile ranks

PORTAGE GUIDE TO EARLY EDUCATION

Author: Portage Preschool Project
Publisher: CESA 12
Box 564
Portage, Wisconsin 53901

Age Range: 0-6 Years

Areas Covered: Cognitive, self-help, motor, language and socialization
Scoring: Developmental levels
Other: Skills are referenced to cards which describe how to teach the skill assessed

PRESCHOOL LANGUAGE SCALE

Author: I.L. Zimmerman, U.G. Steiner, C.L. Evatt
Publisher: Charles E. Merrill
Columbus, Ohio 43216

Age Range: 1-6 Years

Areas Covered: Auditory comprehension, verbal ability
Scoring: Developmental ages

SEEC MINIWHEEL AND MAXIWHEEL OF DEVELOPMENTAL MILESTONES

Author: J. Swanson
Available From: Early Childhood Education
804 West Bode Road
Schaumburg, Illinois 60194

Age Range: 0-5 Years

Areas Covered: Gross motor, fine motor, expressive language, cognitive, personal-social
Scoring: Each item evaluated individually
Other: Observational tool, items derived from Piaget

APPENDIX F

A National List of Voluntary Organizations in Medical Genetics and Maternal and Child Health

December, 1983

(Reprinted with permission of the National Center for Education in Maternal and Child Health, 3520 Prospect Street N.W., Washington, D.C. 20057)

ADOPTION

*AASK America (Aid to Adoption of Special Kids) (415) 543-AASK
595 Market Street
21st Floor
San Francisco, California 94105

ADRENOLEUKODYSTROPHY (See also Leukodystrophy)

ALD Project (301) 955-4051
c/o The JFK Institute for Handicapped Children
707 North Broadway
Baltimore, Maryland 21205
Hugo Moser, M.D., Director

ALBINISM & HYPOPIGMENTATION

*National Organization for Albinism and Hypopigmentation (NOAH) (215) 627-3501
919 Walnut Street, Room 400
Philadelphia, Pennsylvania 19107
Jan Knuth, President

ARTHRITIS

*Arthritis Foundation (404) 872-7100
1314 Spring Street, N.W.
Atlanta, Georgia 30309
Clifford M. Clarke, President

ARTHROGRYPOSIS

*Avenues (Arthrogryposis) (206) 871-5057
5430 East Harbor Heights
Port Orchard, Washington 98366
Mary Ann Schmidt, Director

* Newsletter

ATAXIA

*National Ataxia Foundation (612) 473-7666
Twelve Oaks Center, Suite 600
15500 Wayzata Boulevard
Wayzata, Minnesota 55391
Contact: Donna Gruetzmacher

*Friedreich's Ataxia Group in America, Inc. (415) 658-7014
P.O. Box 11116
Oakland, California 94611
Raymond S. McCarthy, President

AUTISM

*National Society for Children and Adults with Autism (202) 783-0125
1234 Massachusetts Avenue, N.W., Suite 1017
Washington, D.C. 20005
Frank Warren, Executive Director

BATTEN DISEASE

*Children's Brain Disease Foundation (Batten Disease) (415) 565-6259
350 Parnassus, Suite 900
San Francisco, California 94117
J. Alfred Rider, M.D., President

BLINDNESS/VISUAL IMPAIRMENT

*American Council of Blind Parents (205) 277-2798
6209 Lycoming Road
Montgomery, Alabama 26117
Jimmy Gibson, President

*American Foundation for the Blind (212) 620-2000
15 West 16th Street
New York, New York 10011
William F. Gallagher, Executive Director

*Association for Macular Diseases (516) 541-4268
P.O. Box 469
Merrick, New York 11566
Nicholai Stevenson, President

*National Association for the Visually Handicapped (212) 889-3141
305 East 24th Street, Room 17-C
New York, New York 10010
Lorraine H. Marchi, Executive Director

*National Organization for Albinism and Hypopigmentation (NOAH) (215) 627-3501
919 Walnut Street, Room 400
Philadelphia, Pennsylvania 19107
Jan Knuth, President

*National Retinitis Pigmentosa Foundation (301) 655-1011
Rolling Park Building
8331 Mindale Circle
Baltimore, Maryland 21207
Dennis L. Hartenstine, Executive Director

CANCER

American Cancer Society (212) 371-2900
777 3rd Avenue
New York, New York 10017
Lane Adams, Executive Vice President

Association for Brain Tumor Research (312) 984-1000
6232 North Pulaski Road (312) 286-5571
Chicago, Illinois 60646
Don Segal, Executive Director

Leukemia Society of America (212) 573-8484
800 Second Avenue
New York, New York 10017
John L. Ewing, Director

CELIAC-SPRUE

*Midwestern Celiac-Sprue Association (515) 270-9689
2313 Rocklyn Drive, Suite 1
Des Moines, Iowa 50322
Tracey Mohns, Executive Director

CEREBRAL PALSY

*National Easter Seal Society (312) 243-8400
2023 West Ogden Avenue
Chicago, Illinois 60612
John Garrison, Executive Director

*United Cerebral Palsy Association, Inc. (212) 947-5770
330 West 34th Street
New York, New York 10001
Robert Schonhorn, Executive Director

* Newsletter

CLEFT LIP/PALATE

*American Cleft Palate Educational Foundation — (412) 624-0625
National Office
331 Salk Hall
University of Pittsburgh
Pittsburgh, Pennsylvania 15261
Jane Garminski, Administrative Secretary

*Prescription Parents (Cleft Lip/Palate) — (617) 479-2463
P.O. Box 426
Quincy, Massachusetts 02269
Contact: Paula Nannacelli

COOLEY'S ANEMIA/THALASSEMIA

AHEPA Cooley's Anemia Foundation — (212) 961-3666
136-56 39th Avenue
Flushing, New York 11354
Stephen S. Scopas, Chairman

*Cooley's Anemia Foundation, Inc. — (212) 598-0971, (800) 221-3571
105 East 22nd Street
New York, New York 10010
Michael Difilippo, Executive Director

CORNELIA DE LANGE SYNDROME

*Cornelia de Lange Syndrome, Inc. — (203) 693-0159
60 Dyer Avenue
Collinsville, Connecticut 06022
Frank Mairano, Executive Director

CRANIOFACIAL DEFORMITIES

Debbie Fox Foundation (for Craniofacial Deformities) — (615) 266-1632
P.O. Box 11082
Chattanooga, Tennessee 37401
Mary Jane Torrance, Executive Director

Society for the Rehabilitation of the Facially Disfigured, Inc. — (212) 340-5400
550 First Avenue
New York, New York 10016
Robert E. Bochat, Executive Director

* Newsletter

CRI-DU-CHAT SYNDROME

Cri-du-Chat Society (804) 786-9632
Department of Human Genetics
Medical College of Virginia
Box 33
MCV Station
Richmond, Virginia 23298
Contact: Judith A. Brown, Ph.D.

CYSTIC FIBROSIS

*Cystic Fibrosis Foundation (301) 881-9130
6000 Executive Boulevard, Suite 309
Rockville, Maryland 20852
Robert J. Beall, Ph.D., National Director

International Cystic Fibrosis (Mucoviscidosis) Association (216) 271-1100
3567 East 49th Street
Cleveland, Ohio 44105
Robert McCreery, President

DEAFNESS/HEARING IMPAIRMENT

*Acoustic Neuroma Association (717) 249-3973
P.O. Box 398
Carlisle, Pennsylvania 17103
Virginia Fickel, President

*Alexander Graham Bell Association for the Deaf (202) 337-5220
3417 Volta Place, N.W.
Washington, D.C. 20007
Sara E. Conlon, Ph.D., Executive President

*Deafness Research Foundation (212) 684-6556
55 East 34th Street
New York, New York 10016
Albert J. Levine, Acting Director

*International Association of Parents of the Deaf (301) 585-5400
814 Thayer Avenue
Silver Spring, Maryland 20910
Patricia E. Brown, President

National Information Center on Deafness (202) 651-5109
Gallaudet College
Washington, D.C. 20002
Loraine DiPetro, Director

* Newsletter

DIABETES

*American Diabetes Association (212) 683-7444
2 Park Avenue
New York, New York 10016
Robert Bolan, M.D., Executive Director

*Juvenile Diabetes Foundation (212) 889-7575
60 Madison Avenue
New York, New York 10010
Karla Shepard, Acting-Executive Director

DOWN SYNDROME

*Association for Children with Down's Syndrome (516) 221-4700
2616 Martin Avenue
Bellmore, New York 11710
Fredda Stimell, Executive Director

*Down's Syndrome Congress (312) 226-0416
1640 West Roosevelt Road
Chicago, Illinois 60608
Thomas O'Neill, President

*National Association for Down's Syndrome (312) 543-6060
P.O. Box 63
Oak Park, Illinois 60303
Sheila Hebein, Executive Director

*National Down Syndrome Society (212) 765-3070
70 West 40th Street (800) 221-4602
New York, New York 10018
Elizabeth Goodwin, President

DYSLEXIA

*Orton Dyslexia Society (301) 296-0232
724 York Road
Baltimore, Maryland 21204

DYSTONIA

Dystonia Foundation (516) 249-7799
425 Broad Hollow Road
Melville, New York 11747
Harvey Ornstein, President

*Dystonia Medical Research Foundation (213) 272-0353
9615 Brighton Way, Suite 416
Beverly Hills, California 90210
Samuel Belzberg, President

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ECTODERMAL DYSPLASIAS

*National Foundation for Ectodermal Dysplasias — (618) 566-2020
108 North First Street, Suite 311
Mascoutah, Illinois 62258
Mary Kaye Richter, Director

EPIDERMOLYSIS BULLOSA

Dystrophic Epidermolysis Bullosa Research Association of America (DEBRA) — (212) 774-8700
2936 Avenue West
Brooklyn, New York 11229
Arlene Pessar, R.N., Executive Director

EPILEPSY

*Epilepsy Foundation of America — (301) 459-3700
4351 Garden City Drive
Landover, Maryland 20785
William McLinn, Executive Vice President

*National Myoclonus Foundation — (212) 758-6851
845 Third Avenue
New York, New York 10022
Bertin J. Diamond, Executive Director

EXSTROPHY

*National Support Group for Exstrophy — (216) 248-6851
5075 Medhurst Street
Solon, Ohio 44139
Contact: Penny Boross

GAUCHER DISEASE

Gaucher's Disease Research Foundation — No Phone Contact
9313 Meadow Hill Road
Ellicott City, Maryland 21043
Louise Glickman, Chairperson

* Newsletter

GENETICS/BIRTH DEFECTS

*March of Dimes Birth Defects Foundation (914) 428-7100
1275 Mamaroneck Avenue
White Plains, New York 10603

National Center for Education (202) 625-8400
in Maternal and Child Health
3520 Prospect Street, N.W.
Washington, D.C. 20057
Contact: Genetics Associate

National Genetics Foundation (212) 586-5800
555 West 57th Street
New York, New York 10019
Ruth Y. Berini, Executive Director

National Organization for Rare Disorders, Inc. (212) 684-2781
c/o National Huntington's Disease Association
1182 Broadway, Suite 402
New York, New York 10001
Ruby Horansky, Executive Director

GLYCOGEN STORAGE DISEASE

*Association for Glycogen Storage Disease (319) 785-6038
Box 896
Durant, Iowa 52747
Mrs. Hollie Arp, President

HANDICAPS

*Association for the Severely Handicapped, The (206) 523-8446
7010 Roosevelt Way, N.E.
Seattle, Washington 98115
Liz Lindley, Executive Director

Clearinghouse on the Handicapped (202) 245-0080
Office of Special Education and
Rehabilitative Services
Department of Education
Switzer Building, Room 3119-S
Washington, D.C. 20202

Foundation for Child Development (212) 697-3150
345 East 46th Street
New York, New York 10017
Orville G. Brumm, Jr., President

*National Easter Seal Society (312) 243-8400
2023 West Ogden Avenue
Chicago, Illinois 60612
John Garrison, Executive Director

HANDICAPS (cont'd)

National Information Center for Handicapped Children and Youth (703) 528-8480
P.O. Box 1492
Washington, D.C. 20013

Parents Campaign for Handicapped Children and Youth (202) 822-7900
1201 16th Street, N.W.
Washington, D.C. 20036
Barbara Scheiber, Director

HEART DISORDERS

American Heart Association (214) 750-5300
7320 Greenville Avenue
Dallas, Texas 75231
Dudley Hasner, Vice President

HEMOCHROMATOSIS (see also Iron Overload)

Hemochromatosis Research Foundation (518) 489-0972
P.O. Box 8569
Albany, New York 12208
Margaret Krikker, M.D., President

HEMOPHILIA

National Hemophilia Foundation (212) 563-0211
19 West 34th Street
New York, New York 10001
Allen P. Brownstein, Executive Director

HUNTINGTON DISEASE

Hereditary Disease Foundation (213) 274-5443
(Huntington's Disease)
9701 Wilshire Boulevard, Suite 1204
Beverly Hills, California 90212
Milton Wexler, Ph.D., Chairman and
Nancy Wexler, Ph.D., President

*Huntington' Disease Foundation of America (212) 757-0443
250 West 57th Street, Suite 2016
New York, New York 10107
George Rosaler, Executive Director

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HUNTINGTON DISEASE (cont'd)

*National Huntington's Disease Association — (212) 684-2781
1182 Broadway, Suite 402
New York, New York 10001
Ruby Horansky, Executive Director

HYDROCEPHALUS

Know Problems of Hydrocephalus, Inc. — (715) 634-2097 (815) 467-6548
Route 1, River Road (Box 210A)
Joliet, Illinois 60436
James Mazzetti, President

ILEITIS AND COLITIS

*National Foundation for Ileitis and Colitis, Inc. — (212) 685-3440
295 Madison Avenue
New York, New York 10017
George Pheobald, Executive Director

IMMUNE DEFICIENCY

Immune Deficiency Foundation — (301) 997-7919
P.O. Box 586
Columbia, Maryland 21045
Contact: Marsha Boyle

IRON OVERLOAD (see also Hemochromatosis)

Iron Overload Diseases Association — (305) 689-6968
5409 Harriet Place
West Palm Beach, Florida 33407
Roberta Crawford, President

JEWISH GENETIC DISEASES

*Dysautonomia Foundation — (212) 889-0300
370 Lexington Avenue, Suite 1504
New York, New York 10017
Lenore Roseman, Executive Director

Gaucher's Disease Research Foundation — No Phone Contact
9313 Meadow Hill Road
Ellicott City, Maryland 21043
Louise Glickman, Chairperson

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JEWISH GENETIC DISEASES (cont'd)

*National Foundation for Jewish Genetic Diseases (212) 682-5550
250 Park Avenue
New York, New York 10177
Joan C. Samsen, Executive Director

*National Tay-Sachs and Allied (516) 569-4300
Diseases Association
92 Washington Avenue
Cedarhurst, New York 11516
Jane Birnbaum, Executive Director

JOSEPH DISEASE

*International Joseph Disease Foundation, Inc. (415) 455-0706
P.O. Box 2550
1832 Holmes Street, Building E
Livermore, California 94550
Rose-Marie Silva, Executive Director

KIDNEY DISORDERS

*National Kidney Foundation (212) 889-2210
2 Park Avenue
New York, New York 10016
John Davis, Executive Director

LEUKODYSTROPHY (see also Adrenoleukodystrophy)

United Leukodystrophy Foundation, Inc. (317) 784-3020
714 Pioneer Drive
Indianapolis, Indiana 46217
Carolyn and Greg Huffer, Directors

LIVER DISORDERS

*American Liver Foundation (201) 857-2626
998 Pompton Avenue
Cedar Grove, New Jersey 07009
Thelma King Thiel, Executive Director

*Children's Liver Foundation (201) 761-1111
28 Highland Avenue
Maplewood, New Jersey 07040
Maxine Turon, Chairperson

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LOWE SYNDROME

*Lowe's Syndrome Association (317) 743-3634
607 Robinson Street
West Lafayette, Indiana 47906
Contact: Kaye McSpadden

LUNG DISORDERS

American Lung Association (212) 245-8000
1740 Broadway
New York, New York 10019
James A. Swomley, Executive Director

LUPUS (Systematic Lupus Erythematosus)

*Lupus Foundation of America, Inc. (314) 872-9036
11921 Olive Boulevard
St. Louis, Missouri 63141
Roger Sturdevant, Staff Vice President

*National Lupus Erythematosus Foundation (213) 885-8787
5430 Van Nuys Boulevard, Suite 206
Van Nuys, California 91401
Tom Bane, Chairman of the Board

*Systemic Lupus Erythematosus Foundation, Inc. (212) 685-4118
95 Madison Avenue, Room 1402
New York, New York 10016
Susan Golick, Director

MAPLE SYRUP URINE DISEASE

*Families with Maple Syrup Urine Disease (606) 849-4679
Route 2, Box 24-A
Flemingsburg, Kentucky 41041

MARFAN SYNDROME

*National Marfan Foundation (516) 883-8712
54 Irma Avenue
Port Washington, New York 11050
Priscilla Ciccariello, Chairperson

MENTAL RETARDATION/DELAYED DEVELOPMENT

Mental Retardation Association of America (801) 328-1575
211 East Third Street South, Suite 212
Salt Lake City, Utah 84111
Elaine F. Sharp, Executive Director

*National Association for Mental Health, Inc. (703) 528-6405
1800 North Kent Street
Arlington, Virginia 22209
Douglas Waterstreet, Executive Director

*National Association for Retarded Citizens (817) 640-0204
2501 Avenue J
Arlington, Texas 76011
Alan Abeson, Ph.D., Executive Director

Retarded Infant Services (212) 889-5464
386 Park Avenue South
New York, New York 10016
Joan M. Joseph, C.S.W., Executive Director

MUCOPOLYSACCHARIDOSIS

*Mucopolysaccharidosis (MPS) Society, Inc. (516) 433-4410
552 Central Avenue
Bethpage, New York 11714
Mary Majure, President

MUSCULAR DYSTROPHY

*Muscular Dystrophy Association (212) 586-0808
810 Seventh Avenue
New York, New York 10019
Robert Ross, Executive Director

MYASTHENIA GRAVIS

Myasthenia Gravis Foundation (212) 889-8157
15 East 26th Street, Room 1603
New York, New York 10010
Robert S. McKanna, Deputy Executive Director

NARCOLEPSY

American Narcolepsy Association (415) 591-7979
P.O. Box 5846
Stanford, California 94305
William Baird, Executive Director

Narcolepsy and Cataplexy Foundation of America (212) 628-6315
1410 York Avenue, #32-D
New York, New York 10021
Bruno G. Ronty, Ph.D., General Director

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NEUROFIBROMATOSIS

*Acoustic Neuroma Association (717) 249-3973
P.O. Box 398
Carlisle, Pennsylvania 17013
Virginia Fickel, President

*National Neurofibromatosis Association (212) 869-9034
70 West 40th Street, Fourth Floor
New York, New York 10018
Felice Yahr, Executive Director

NEUROLOGIC DISORDERS

*Center for Neurologic Study (619) 455-5463
11211 Sorrento Valley Road, Suite H
San Diego, California 92121
Richard A. Smith, M.D., Director

NEUROMETABOLIC DISORDERS

*Association for Neurometabolic Disorders (419) 475-6331
2707 Cheltenham
Toledo, Ohio 43606
Contact: Cheryl Volk

*Families with Maple Syrup Urine Disease (606) 849-4679
Route 2, Box 24-A
Flemingsburg, Kentucky 41041

*PKU Parents Group (Phenylketonuria) (415) 941-9799
518 Paco Drive
Los Altos, California 94022
Donna Jahn, President

OSTEOGENESIS IMPERFECTA

*American Brittle Bone Society (215) 692-6248
1256 Merrill Drive
West Chester, Pennsylvania 19380
Robert DeVito, Executive Director

*Osteogenesis Imperfecta Foundation, Inc. (603) 623-0934
P.O. Box 838
Manchester, New Hampshire 03105
Gemma Geisman, Executive Director

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PHENYLKETONURIA

*PKU Parents Group (415) 941-9799
518 Paco Drive
Los Altos, California 94022
Donna Jahn, President

PRADER-WILLI SYNDROME

*Prader-Willi Syndrome Association (612) 933-0113
5515 Malibu Drive
Edina, Minnesota 55436
Delfin Beltran, President

PROGERIA

Progeria International Registry (212) 494-5231
New York State Institute for Basic Research
in Developmental Disorders
1050 Forest Hill Road
Staten Island, New York 10314
W. Ted Brown, M.D., Ph.D., Director

RETINITIS PIGMENTOSA

*National Retinitis Pigmentosa Foundation (301) 655-1011
Rolling Park Building
8331 Mindale Circle
Baltimore, Maryland 21207
Dennis L. Hartenstine, Executive Director

REYE SYNDROME

National Reye's Syndrome Foundation (616) 882-5521
7045 Trevers Avenue
Benzonia, Michigan 49616
John W. Dieckman, President

SCOLIOSIS

National Scoliosis Foundation, Inc. (617) 489-0888
48 Stone Road
Belmont, Massachusetts 02178
Laura B. Gowen, President

Scoliosis Association, Inc. (212) 845-1760
One Penn Plaza
New York, New York 10119
Kurt Enslein, Executive Director

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Scoliosis Research Society (312) 822-0970
American Academy of Orthopedic Surgeons
444 North Michigan Avenue
Chicago, Illinois 60611
Robert Hensinger, Secretary

SHORT STATURE/DWARFISM

*Human Growth Foundation (301) 656-7540
4607 Davidson Drive
Chevy Chase, Maryland 20815
Denise Orenstein, Executive Director

SHORT STATURE/DWARFISM (cont'd)

*Little People of America (415) 589-0695
P.O. Box 633
San Bruno, California 94066
Mary Carter, President

Parents of Dwarfed Children (301) 649-3275
11524 Colt Terrace
Silver Spring, MD 20209
Contact: Margaret Badner

Turner's Syndrome Support Group No Phone Contact
700 Easton Avenue
Somerset, New Jersey 08873
Contact: Madeline Lozowski

SICKLE CELL

*National Association for Sickle Cell Disease, Inc. (213) 731-1166
3460 Wilshire Boulevard, Suite 1012
Los Angeles, California 90010
Dorothy Boswell, Executive Director

SKIN DISORDERS

*Dystrophic Epidermolysis Bullosa Research Association of America (DEBRA) (212) 774-8700
2936 Avenue West
Brooklyn, New York 11229
Arlene Pessar, R.N., Executive Director

*National Foundation for Ectodermal Dysplasias (618) 566-2020
108 North First Street, Suite 311
Mascoutah, Illinois 62258
Mary Kaye Richter, Director

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*National Organization for Albinism and Hypopigmentation (NOAH) (215) 627-3501
919 Walnut Street, Room 400
Philadelphia, Pennsylvania 19107
Jan Knuth, President

SPINA BIFIDA

*Spina Bifida Association of America (312) 663-1562
343 South Dearborn, Room 317
Chicago, Illinois 60604
Kent Smith, Executive Director

SUDDEN INFANT DEATH SYNDROME

Council of Guilds for Infant Survival (SIDS) (319) 322-4870
P.O. Box 3841
Davenport, Iowa 52808
Kathy Paulson, Coordinator

*National Sudden Infant Death Syndrome Foundation (301) 459-3388
2 Metro Plaza, Suite 204
8240 Professional Place
Landover, Maryland 20785
Edith McShane, Acting Executive Director

TAY-SACHS DISEASE

*National Tay-Sachs and Allied Diseases Association (516) 569-4300
92 Washington Avenue
Cedarhurst, New York 11516
Jane Birnbaum, Executive Director

National Tay-Sachs Parent Peer Group (516) 938-1379
12 Linda Lane
Plainview, New York 11803
Susan Levy and Marcia Levinson, Chairpersons

THROMBOCYTOPENIA ABSENT RADIUS SYNDROME

TARSA (Thrombocytopenia Absent Radius Syndrome) No Phone Contact
312 Sherwood Drive, R.D. 1
Linwood, New Jersey 08221
Contact: Sandra Purinton

* Newsletter

TOURETTE SYNDROME

*Tourette Syndrome Association, Inc. (212) 224-2989
41-02 Bell Boulevard
Bayside, New York 11361
Patricia Breslin, Executive Administrator

TRISOMY 18/13

*Support Organization for Trisomy 18/13 (801) 882-6635
478 Terrace Lane
Tooele, Utah 84074
Kris Holladay, Coordinator

TUBEROUS SCLEROSIS

*National Tuberous Sclerosis Association, Inc. (312) 668-0787
P.O. Box 612
Winfield, Illinois 60190
Barbara Lawlor, President

*Tuberous Sclerosis Association of America (617) 878-5528
P.O. Box 44
Rockland, Massachusetts 02370
Raymond A. Connors, President

TURNER SYNDROME (see also Short Stature/Dwarfism)

Turner's Syndrome Support Group No Phone Contact
700 Easton Avenue
Somerset, New Jersey 08873
Contact: Madeline Lozowski

WILLIAM SYNDROME

National Organization for Parents of Williams (619) 276-7531
3254 Clairemont Drive
San Diego, California 92117
Contact: Diane Filley

WILSON DISEASE

Wilson's Disease Association (Wilson's Disease & Menkes' Steely Hair) (703) 221-5532
P.O. Box 489
Dumfries, Virginia 22026
Carol Terry, Vice President

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GENERAL SUPPORT/SELF-HELP GROUPS

Aiding a Mother Experiencing (213) 887-7999
Neo-Natal Death (AMEND)
P.O. Box 30
Harbor City, California
Dorothy Medrano, Executive Director

Association for the Care of Children's Health (202) 244-1801
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016
Beverly H. Johnson, Executive Director

Children in Hospitals (617) 482-2915
31 Wilshire Park
Needham, Massachusetts 02192

*Compassionate Friends, Inc. (312) 323-5010
(Bereaved Parents)
P.O. Box 1347
Oak Brook, Illinois 60521
Art Peterson, Executive Director

Family Resource Coalition (312) 726-4750
(Health Promotion)
230 North Michigan Avenue, Suite 1625
Chicago, Illinois 60601
Linda Lipton, Director

Make Today Count, Inc. (319) 753-6521
(Parents of Seriously Ill Children)
Box 303
Burlington, Iowa 52601

National Self-Help Clearinghouse (212) 840-7606
Graduate Center
City University of New York
33 West 42nd Street, #1227
New York, New York 10036

*Parentele (317) 926-4142
(Parents of Children With Handicaps)
1301 E. 38th Street
Indianapolis, Indiana 46205
Pat Koerber, President

Parents Helping Parents (408) 272-4774
47 Maro Drive
San Jose, California 95127
Florene Poyadue, R.N., M.A., Executive Director

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National Clearinghouse for Mental Health Information
Public Inquiries Section
Room 15C-17
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-4513

National Diabetes Information Clearinghouse
Box NIDC
Bethesda, Maryland 20205
(301) 468-2162

National Health Information Clearinghouse
P.O. Box 1133
Washington, D.C. 20013-1133
(703) 522-2590
(800) 336-4797

National Information Center for Handicapped Children and Youth
P.O. Box 1492
Washington, D.C. 20013
(703) 528-8480

National Institute of Child Health and Human Development
Building 31, Room 2A32
9000 Rockville Pike
Bethesda, Maryland 20205
(301) 496-5133

National Institutes of Health
Office of the Director
Building 31, Room 2B03
9000 Rockville Pike
Bethesda, Maryland 20205
(301) 496-4143

National Library Service for the Blind and Physically Handicapped
Library of Congress
1291 Taylor Street, N.W.
Washington, D.C. 20542
(202) 287-5100
(800) 424-8567

National Rehabilitation Information Center
The Catholic University of America
4407 Eighth Street, N.E.
Washington, D.C. 20017
(202) 635-5826

Sickle Cell Disease Branch
National Heart, Lung and Blood Institute
National Institutes of Health
Federal Building, Room 508
7500 Wisconsin Avenue
Bethesda, Maryland 20205
(301) 496-6931

Sudden Infant Death Syndrome Clearinghouse
1555 Wilson Boulevard, Suite 600
Rosslyn, Virginia 22209
(703) 528-8480

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SELECTED FEDERAL INFORMATION CLEARINGHOUSES

AND NATIONAL RESOURCE CENTERS

Arthritis Information Clearinghouse (703) 558-8250
P.O. Box 9782
Arlington, VA 22209

Center for Birth Defects Information (617) 956-7400
Services (BDIS)
171 Harrison Avenue
Box 403
Boston, MA 02111

Cancer Information Clearinghouse (301) 496-6641
Office of Cancer Communications (800) 4-CANCER
National Cancer Institute
9000 Rockville Pike
Building 31, Room 10A21
Bethesda, MD 20205

Centers for Disease Control (404) 452-4080
Birth Defects Branch
1600 Clifton Road, N.E.
Chamblee Building 5
Atlanta, GA 30333

Clearinghouse on the Handicapped (202) 245-0080
400 Maryland Avenue, S.W.
Switzer Building, Room 3119
Washington, D.C. 20202

Closer Look Information Center (202) 822-7900
(Parents Campaign for Handicapped
Children and Youth)
1201 Sixteenth Street, N.W.
Washington, DC 20036

Food and Drug Administration (301) 443-3170
Office of Consumer Affairs
5600 Fishers Lane, HFE-88
Rockville, MD 20857

Food and Nutrition Information Center (301) 344-3719
Room 304
National Agricultural Library Building
Beltsville, MD 20705

Inter-Institute Clinical Genetics Program (301) 496-1380
National Institutes of Health
Building 10, Room 1D21
Bethesda, MD 20205

* Newsletter

A NORTH DAKOTA LIST OF RESOURCES AND ORGANIZATIONS
FOR PARENTS AND PROFESSIONALS

The Coalition for Disabled Persons of North Dakota
15 South 21st Street Suite 1-W
Fargo ND 58103
(800) 342-4587
(701) 232-3371

Crippled Children's Services
Robert Nelson, Administrator
State Capitol
Bismarck ND 58505
(701) 224-2436

Medical Services
Ms. Doris Schell
Department of Human Services
State Capitol
Bismarck ND 58505
(701) 224-2323

(Agency Administering the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)

North Dakota Association for Persons with Severe Handicaps (NDASH)
c/o Brent Askvig
Minot Infant Development Program
Minot State College
Minot ND 58701
(701) 857-3821

North Dakota Association for Retarded Citizens
Dan Ulmer, Executive Director
418 East Broadway
Bismarck ND 58501
(701) 223-5349

North Dakota Department of Human Services
Darvin Hirsch, Director
Developmental Disabilities Division
State Capitol
Bismarck ND 58505
(701) 224-2768

North Dakota Department of Public Instruction
Gary Gronberg
Director of Special Education
State Capitol - 10th Floor
Bismarck ND 58505
(800) 932-8974
(701) 224-2277

A NORTH DAKOTA LIST OF RESOURCES AND ORGANIZATIONS
FOR PARENTS AND PROFESSIONALS

North Dakota Developmental Disabilities Council (701) 224-2970
Tom Wallner
Department of Human Services
State Capitol
Bismarck ND 58505

North Dakota Down's Syndrome Congress (701) 772-6191
Attn: Dagne Olson (701) 696-2322
Box 402
Grand Forks ND 58201

North Dakota Parents of Deaf-Blind (701) 224-4511
and Multihandicapped Children, Inc. (701) 223-6224
Rosemary Horning
P O Box 10
Bismarck ND 58501

North Dakota Parent-Infant Program (701) 662-5031
for the Hearing Impaired
North Dakota School for the Deaf
Devils Lake ND 58301

Parents Anonymous of North Dakota (701) 255-6240
311 East Thayer Avenue
Bismarck ND 58501

or

Parents Anonymous
22330 Hawthorne Boulevard, Suite 208
Torrance CA 90505

(This organization is for adults who have abused children. The aim is to re-educate abusers and promote the well-being of children. Provides relief in time of crisis.)

Protection and Advocacy Project for the (800) 472-2670
Developmentally Disabled (701) 224-2972
Barbara C. Braun, Project Director
Governor's Council on Human Resources
State Capitol Annex - First Floor
Bismarck ND 58505

TRANSITIONS

Let's Talk About Moving On

The content of this brochure is adapted from a brochure produced by the Tennessee Early Intervention Network for Children with Handicaps (TENICH), Box 151, Peabody College of Vanderbilt University, Nashville TN 37203. The information is reprinted with the permission of TENICH.

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MOVING ON....families of children with handicaps are excited about the change from preschool to programs for school-age children, but they may have concerns. Who will be their child's teacher? Will she understand their child's special needs? What will their child do in the new classroom? Will the teacher understand the progress their child has made in preschool?

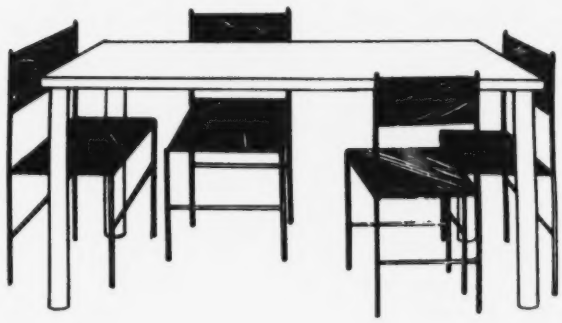
Both sending teacher and parents may have difficulty letting go of a child with special needs and moving that child from the protective environment of the preschool to a setting with more children and more staff. Some parents may be struggling with the realization that their child's development has not reached the level of other children's development, therefore the child is being placed in a special classroom. Other parents may have concerns about how their children with special problems will be treated in a mainstreamed classroom and if their individual needs will be met.

A smooth transition can best be accomplished when sending teachers, receiving teachers, parents, and administrators of both school settings communicate frequently and plan together. Preschool staff can help prepare children for new settings and help parents have a positive attitude toward the staff in the new program. The receiving program staff need to be informed about preschool programs, seek assistance from preschool teachers in understanding the children, and provide information about what the new setting has to offer. An evaluation and planning group of school and preschool staff members and parents meeting together can identify transition problems and plan ways to overcome these problems. They can help to build trust, establish avenues of communication, and ensure cooperation among sending teachers, receiving teachers, administrators, and parents. Working together they can make sure that "moving on" to a new classroom progresses as smoothly as possible for the children with handicaps and their families.

ADMINISTRATORS

Some difficulties related to transition have been identified. Preschool staff often feel that other school personnel ignore them and fail to recognize what they have taught and what they have learned about the children in their programs. School staff sometimes state that preschool personnel cause parents to have negative attitudes toward school programs and assume they will have to fight to get services for their children.

Both regular education and special education administrators have the responsibility to set a tone of cooperation and willingness to work together. They have the responsibility for making sure that procedures are established which will coordinate the efforts of all those who are seeking to provide needed services for children with handicaps and their families.



Suggested Checklist for Administrators

-Make sure child-find is ongoing.
-Share information about children who are ready to move on as early as possible.
-Designate a contact person to handle transition.
-Provide release time for teachers to visit preschool programs.

-Provide teachers with time for follow-up contacts.
-Be sure parents and teachers are in touch with each other and are receiving all necessary information. Keep information flowing.
-Share services and materials between preschool and other school programs as appropriate.
-Set up staffings or multidisciplinary meetings.
-Include sending and receiving teachers.
-Provide parents with information about their children's rights and their rights.
-Follow state regulations in accordance with Public Law (P.L.) 94-142 in placing children.
-Provide parents with a list of information that the school needs about their children.
-Provide parents with training opportunities on how to be involved in school and how to express concerns.
-Learn about the preschool and school-age programs for handicapped children as well as regular kindergarten programs.
-Be sure children have appropriate diagnostic tests and assessments or progress to ensure placement and continued progress.
-Whenever possible, provide placement and programing options for children and families.

SENDING TEACHERS

Sending teachers have had the opportunity to learn about children's learning styles, strengths and weaknesses, and what support services might be needed. They have had the opportunity to establish rapport with parents and develop an understanding of their needs and concerns. They can help prepare both children and parents for moving on.

Suggested Checklist for Sending Teachers

-Keep good records of evaluations, child progress, and suggessful teaching strategies.
-Visit receiving classrooms.
-Teach children social, self-help, and group skills that they will need in the next environment.
-Provide the school with information about children who will be coming.
-Ask parents to sign release forms for information to be sent to schools.
-Provide parents with a copy of school records and encourage them to keep a notebook or file.
-Meet informally with receiving teachers.
-Support and document requests made to the school for services.
-Help determine the most appropriate and least restrictive placement.
-Provide reassurance, support, and guidance for families and children.
-Complete a short information form to provide receiving teachers with pertinent information as soon as children's new placements are determined.
-Convey a positive attitude.
-Remain in touch with the receiving teachers during the year to provide follow-up consultation.

RECEIVING TEACHERS

The receiving teachers help children maintain the progress they have made in the preschool and continue to develop more skills and greater independence. Through their contacts with parents and sending teachers, the receiving teachers learn more about children's achievements and what problems they are experiencing. They make the transition easier by being flexible in their expectations and their plans for new students.

Suggested Checklist for Receiving Teachers

-Visit preschool programs to observe classroom procedures and teaching strategies and to learn about curriculum and support services.
-Plan an open house for preschool teachers, parents, and children to see the school program.
-Get acquainted with parents of children coming to your classes before school starts with either a phone call or a visit. Find out about parents' expectations for their children.
-Provide parents with a packet of information about the school, including the teacher's name, transportation arrangements, and meal arrangements.
-Review all records on children maintained by the preschool.
-Attend multidisciplinary team meetings.
-Confer with the sending teachers to learn about children's strengths and weaknesses. Include them in IEP meetings for the children.
-Prepare children in a mainstreamed classroom for a child with a disability.
-Provide emotional support and, if possible, refer parents to support groups.
-Be flexible in planning for children and parents.
-Continue to confer with sending teachers during the year about children's progress and problems.
-Provide suggestions to help sending teachers prepare children for school classrooms.
-Arrange for appropriate related services.

PARENTS

Parents know their children better than anyone else does. They need a balance of caution along with optimism in planning for their children's futures. They need to learn to work with professionals, being open to diagnoses and prognoses but continuing to evaluate the information given in the light of their knowledge of their children's development.

Parents usually become experts in their knowledge about their children's disabilities. They also need to be experts in their knowledge about their children's educational rights including the provisions of Public Law 94-142, the multidisciplinary team, and their children's individual education plan (IEP). Parents are the ones who seek a match between services available or potentially available in their community and the services their children need. When participating in staffings, parents should be confident about the contribution they have to make based on their knowledge about, concern for, and love of their children. When an educational program is not satisfactory, parents need to know how to work with the school to seek changes.

Parents also have the responsibility to balance their own needs and those of their families with the needs of their children with handicaps. In some cases they will have to evaluate suggestions for additional services for their children in terms of their overall family situations. Other parents who have children with handicaps may be able to provide support and encouragement either informally or through parent support groups. Seeking help when difficulties arise is an indication of strength, not weakness.

The checklist that follows will assist parents to be prepared for their children's transition from a preschool to other school programs.

Suggested Checklist for Parents

-Request copies of all reports of evaluations, teacher summaries, and medical reports on your child.
-Keep a file or notebook of all records on your child including the following:
    -Doctors' reports
    -Teachers' reports
    -Diagnostic evaluations
    -Record of immunizations
-Ask questions about any reports you do not understand.
-Learn about the provisions of Public Law 94-142 for your child's education including the following:
    -Individual Education Plan (IEP)
    -Multidisciplinary team
    -Related services
    -Least restrictive environment
    -Your right of access to your child's records
    -Your right to refuse to sign the IEP and your right to call a multidisciplinary team meeting.
    -Your right to request a due process hearing
-Visit school programs available for your child.
-Provide the school with records required including records of:
    -Physical examinations
    -Immunizations
    -Certification of specific disability from appropriate medical specialist
    -Records of diagnostic evaluations
-Inform school of all previous services your child has received.
-Make choices for your child's education based on all available information: evaluations, preschool performance, knowledge of your child, and professional advice.
-Get to know the receiving teacher as early as possible.
-Participate in staffings and be confident in your knowledge of your child.
-Know how to work with the school to seek changes in your child's educational program when needed.